King County

Department of
Phone:
Fax:
Email:

Physical Restrictions Form

Employee's Name:	Visit Date:	
Health-care Provider's Name (printed):		

☐ Employee is **released** to work without restrictions as of (date): ____/____/____

☐ Employee **may perform modified duty**, if available, from (date):
_____/_____/_____ to _____/_____/_____

☐ Employee **may work limited hours**: _____hours/day from (date):
_____/_____/_____ to _____/_____/_____

☐

☐ Employee **not released to any work** from (date): ____/____/____ to ____/____/____

☐ Please estimate capacities below:

☐

Required: Estimate what the worker can do *Unless released witout restrictions*

Capacity duration (estimate days): ☐ **1-10** ☐ **11-20** ☐ **21-30** ☐ **30+** ☐ **permanent**

Worker can: (Related to work injury.) Blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% Not restricted
Sit					
Stand / Walk					
Climb (ladder / stairs)					
Twist					
Bend / Stoop					
Squat / Kneel					
Crawl					
Reach **L**eft, **R**ight, **B**oth					
Work above shoulders **L**, **R**, **B**					
Keyboard **L**, **R**, **B**					
Wrist (flexion/extension) **L**, **R**, **B**					
Grasp (forceful) **L, R, B**					
Fine manipulation **L**, **R**, **B**					
Operate foot controls **L**, **R**, **B**					
Vibratory tasks; high impact					
Vibratory tasks; low impact					

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift **L**, **R**, **B**	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs
Carry **L**, **R**, **B**	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs
Push / Pull **L**, **R**, **B**	____ lbs	____ lbs	____ lbs	____ lbs	____ lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐Yes ☐No
Modified duty available? ☐Yes ☐No

Comments:

☐ Next scheduled visit in: _____ days, _____weeks ***OR***
Date: _____/_____/_____

Any permanent restrictions? ☐Yes ☐No ☐Possibly

Sign

Signature (**Required**): _____ ( )____-_____ Date: _____/_____/_____
☐ Doctor ☐ ARNP ☐ PA-C Phone number

☐ Copy given to employee