Claimant Name: Social Security Number:

Other Providers: Please supply complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #	Fax #	Treatment From	Treatment To
	N/A					

Physical Capabilities

a) Patient's ability to: *(Please Check Number of Hours Per Workday and How Often)*

	Number of Hours	How Often
Sit	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☒8	☐ Continuously ☐ Intermittently
Stand	☐0 ☐1 ☒2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	☐ Continuously ☐ Intermittently
Walk	☐0 ☑1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8	☐ Continuously ☐ Intermittently

b) Patient's ability to: *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Climb	☒	☐	☐	☐
Twist/bend/stoop	☐	☒	☐	☐
Reach above shoulder level	☐	☐	☐	☒
Operate heavy machinery	☒	☐	☐	☐

c) Patient's ability to lift/carry: *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Up to 10 lbs.	☐	☒	☐	☐
11 to 20 lbs.	☒	☐	☐	☐
21 to 50 lbs.	☒	☐	☐	☐
51 to 100 lbs.	☒	☐	☐	☐

d) Patient's ability to perform: *(Please Check)*

	Never 0% R	Never 0% L	Occasionally 1-33% R	Occasionally 1-33% L	Frequently 34-66% R	Frequently 34-66% L	Continuously 67-100% R	Continuously 67-100% L
Fine Finger movements	☐	☐	☒	☒	☐	☐	☐	☐
Hand/eye coordinated movements	☐	☐	☒	☒	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☒	☒	☐	☐	☐	☐

Dominant Hand ☑ Right ☐ Left

Psychological Features

Are there any cognitive deficits or psychiatric conditions that interfere with the patient's ability to perform his/her occupation? If so, please describe specifically how any identified condition prevents the patient from performing his/her occupation.

Return to Work

a) When do you expect improvement in the patient's capabilities?

b) Have you advised patient to return to work? ☐ Yes ☐ No Expected Return to Work Date: ☐ Full Time ☐ Part Time
If yes, please indicate any ongoing restrictions and limitations in the space provided below.
If no, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided below.

c) RESTRICTIONS (activities patient should not do)

d) LIMITATIONS (activities patient cannot do)

kneel, squat, crawl

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Print or Type Name: DONALD L. ROSSMAN | Degree: M.D | Medical Specialty: occ health

Street Address: DAMERON OCCUPATIONAL HEALTH SERVICES 525 W. ACACIA STREET • STOCKTON CA 95203 | Telephone Number: (209) 461-3196

City | State | ZIP Code | Fax (209)

Signature of Physician | Date 7/29/08

SSN or Employer's ID Number: | Are you, the physician, related to this patient? ☐ Yes ☐ No If yes, what is the relationship?

1185-02 (06/08)