Environmental Health and Safety Coordinator
City Of Winona
207 Lafayette Street
Winona, MN 55987
507-457-8255 – Office
507-457-8293 - Fax

Work Capacities Form

Employee Name: _____**Job Title:** _____

Injured body part/diagnosis: _____

The above named person has sustained an injury/illness that may prevent them temporarily from performing their normal duties. The physical capabilities enclosed should help us in our efforts to return our employees to a safe work environment. Thanks for your assistance.

Employee may return to work without restrictions. ____Yes ____No

Maximum Physical Capacities:

1. For an 8-hour day, the employee can: (Circle total hours)
   - A. Sit 1 2 3 4 5 6 7 8
   - B. Stand 1 2 3 4 5 6 7 8
   - C. Walk 1 2 3 4 5 6 7 8

2. Person can:

		Not at all	**Occasionally** (1% - 33%)	**Frequently** (34% - 66%)	**Continuously** (67% - 100%)
A.	Bend/Stoop	_____	_____	_____	_____
B.	Reach	_____	_____	_____	_____
C.	Crouch/Crawl	_____	_____	_____	_____
D.	Kneel	_____	_____	_____	_____
E.	Climb	_____	_____	_____	_____

3. Employee can carry/lift:

A.	Up to 10 lbs.	_____	_____	_____	_____
B.	11-20 lbs.	_____	_____	_____	_____
C.	21-50 lbs.	_____	_____	_____	_____
D.	Over 50 lbs.	_____	_____	_____	_____

4. Employee can use arm/hand for repetitive action such as keyboard operation or machinery controls:
   Right Arm/Hand ___Yes ___No
   Left Arm/Hand ___Yes ___No

5. Employee can use leg/foot for repetitive action such as driving or machinery controls:
   Right Leg/Foot ___Yes ___No
   Left Leg/Foot ___Yes ___No

6. Is employee receiving any treatment and/or medication that would affect mental alertness/awareness? ____Yes ____No

Additional Comments: _____

_____

Physician's Signature: _____ Date: _____

Printed Name: _____ Next Appointment Date: _____

Employee: Please read, sign and date:

1. I was informed of the above restrictions and instructions, and understand that these restrictions apply to my activities both at work and during non-work hours and activities.
2. I authorize release of necessary medical information to my employer.

Employee's Signature _____Date _____

Supervisor’s Signature_____ Date _____