STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

Send Completed Form To:
Zurich Insurance
PO Box 66941
Chicago, IL 60666-0941
FAX: 847-240-8172

PHYSICIAN STATEMENT OF PHYSICAL CAPABILITIES
PLEASE CHECK ALL THAT APPLY

Claimant Name	Claim Number
Physician Name, Address and Phone Number	Social Security Number – last four digits
	Date of Injury
	Injury Diagnosis
	Maximum Medical Improvement Achieved?

None Not at all	Occasionally Up to 1/3 of the time	Frequently 1/3 to 2/3 of the time	Constantly More than 2/3 of the time

Activity	None	Occasionally	Frequently	Constantly	Unrestricted
SIT					
STAND					
WALK					
LIFT, CARRY, PUSH OR PULL					
Negligible Weights					
Up to 10 pounds					
11 to 20 pounds					
21 to 35 pounds					
36 to 50 pounds					
51 to 75 pounds					
76 to 100 pounds					
Over 100 pounds					
STOOP/BEND					
CROUCH/SQUAT					
TWIST/TURN					
KNEEL/CRAWL					
CLIMB					
REACH ABOVE SHOULDER					
GRASP RIGHT HAND					
GRASP LEFT HAND					
OPERATE RIGHT FOOT CONTROL					
OPERATE LEFT FOOT CONTROL					
DRIVE STANDARD					
DRIVE AUTOMATIC					
KEYBOARD					

Return to work with above restrictions: _____ / _____ / _____	Restrictions in effect until: _____ / _____ / _____
Physician Signature	Date

INSTRUCTIONS FOR PHYSICIAN USE OF THE PHYSICIAN STATEMENT OF PHYSICAL CAPABILITIES

The employer may be able to provide your patient restricted duty if they have adequate information on which to make that decision. That information can only come from the treating physician.

This form is presented as an alternative for the treating physician to provide a detailed statement regarding the injured worker's work restrictions.
If the physician prefers to provide such information in another format (for example, on a form already used in that office or as a comment on a work release), that is certainly acceptable.

In any case it is essential the work restrictions be adequately defined and specific.
Additionally, the time frame for the restrictions must always be stated.
For this Physician Statement of Physical Capabilities form:

- Provide all the information requested in the upper portion of the form.
- Check or otherwise mark the frequency with which the injured worker can sustain the listed activities.
- Skip marking those activities not relevant to the instant injury.
- State the return to work date and end date for the stated restriction.
- Sign and date the form.
- Return the completed form to the address in the upper right corner.