GEORGIA DEPARTMENT OF HUMAN SERVICES
Human Resources Policy #1703 A1

ATTENDING PHYSICIAN'S FUNCTIONAL CAPABILITY STATEMENT

Employee's Name | **Social Security #**

Home Address | **City** | **State** | **Zip** | **Employee's Phone Number**

Work Address | **City** | **State** | **Zip**

History and Statement of Medical Facts (Physical and Psychological)

A. Date symptoms first appeared/accident occurred:

B. Date patient ceased worked:

C. Date of First Visit:

D. Date of most recent examination:

E. Frequency of Visits:

F. Past History:

G. Objective Findings (including test results):

H. Subjective symptoms:

I. State Primary medical facts affecting work ability:

J. State secondary medical facts affecting work ability:

K. Present and future course of treatment:

L. Other known or resent active diseases that may affect work activities:

Due to patient's medical condition, select the limitations on any of the activities listed below. Check appropriate box and explain.

Activity	No Limitations	Some Limitations	Avoid Completely	Cannot Determine
Ability to drive	☐	☐	☐	☐
Ability to ride	☐	☐	☐	☐
Use of public transportation	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Sit	☐	☐	☐	☐
Assume Cramped/Unusual Position	☐	☐	☐	☐
Reach (forward/overhead)	☐	☐	☐	☐

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Activity	No Limitations	Some Limitations	Avoid Completely	Cannot Determine
Grasp/Handle	☐	☐	☐	☐
Repetitive Movement (hands/feet)	☐	☐	☐	☐
Climb (stairs/ladders/scaffolds)	☐	☐	☐	☐
Bend/Stoop/Squat	☐	☐	☐	☐
Operate Truck/Dolly/Small Vehicle	☐	☐	☐	☐
Operate Heavy Equipment	☐	☐	☐	☐
Concentrate Visual Attention	☐	☐	☐	☐
Other:	☐	☐	☐	☐
Explanation:				

Evaluation of carrying and lifting abilities includes both the intensity and frequency of the activity. For each weight class listed below, please indicate the reasonable top limit of frequency. Provide an explanation below with any additional comments regarding limitations on duration, ability to handle and distance (in front of body and above floor).

Intensity	Never	Less than 20%	20% — 60%	Greater than 60%
0 – 15	☐	☐	☐	☐
16 – 30	☐	☐	☐	☐
31 – 45	☐	☐	☐	☐
Greater than 45	☐	☐	☐	☐
Explanation:				

Is there a medical problem, either physical or psychological, that accompanies the current medical condition, which might interfere with the patient's ability to work? If yes, please list your findings according to the DSM-III multiaxial classification below.

☐ **Yes** ☐ **No** ☐ **Not Determined**

Findings:

Indicate below if you have additional information relevant to this patient's ability to work. Please refer to the employee's job description and, if necessary, discuss them with the patient.

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Disability Evaluation	For Current Occupation	For Any Occupation
Is patient currently totally disabled?	☐ Yes ☐ No ☐ Cannot Determine	☐ Yes ☐ No ☐ Cannot Determine
If no, when is patient able to resume work activities?	Date: ☐ Cannot Determine	Date: ☐ Cannot Determine
If yes, is patient able to resume work activities?	☐ Yes ☐ No ☐ Cannot Determine	☐ Yes ☐ No ☐ Cannot Determine
If yes, when is patient able to resume work activities?	Date: ☐ Cannot Determine	Date: ☐ Cannot Determine

Progress Evaluation		
Recovered	☐ Yes	☐ No
Improved	☐ Yes	☐ No
Unimproved	☐ Yes	☐ No
Retrogressed	☐ Yes	☐ No

Physician Name **Board Certified Specialty**

Street Address **City** **State** **Zip**

Physician Signature **Telephone Number** **Date**