encova INSURANCE

PHYSICIAN STATEMENT OF PHYSICAL CAPABILITIES

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

Claimant name	Claimant number	Date of injury

Please complete this form after your examination of the patient. Indicate the patient's capabilities, including work hours, duties, environmental factors and any other information pertinent to this employee's recovery and early return to work.

Medical diagnosis

Please indicate the extent to which the employee can perform the following work postures and work activities during the usual workday.

Standing	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Sitting	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Walking	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Climbing	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Kneeling	☐ Constantly	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
	>67% of workday	34% - 66% of workday	6% - 33% of workday	<5% of workday	0% of workday

Please indicate the extent to which the employee can perform the following:
(C - Constantly = greater than 67% F - Frequently = 34% to 66% O - Occasionally = 6% to 33% R - Rarely = Less than 5% N - Never = 0%)

Lifting/carrying	**C**	**F**	**O**	**R**	**N**
5 lbs. or less	☐	☐	☐	☐	☐
5–10 lbs.	☐	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐	☐
21–40 lbs.	☐	☐	☐	☐	☐
41–60 lbs.	☐	☐	☐	☐	☐
61–100 lbs.	☐	☐	☐	☐	☐
100+ lbs.	☐	☐	☐	☐	☐
Activity					
Bend	☐	☐	☐	☐	☐
Squat	☐	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐	☐
Crawl	☐	☐	☐	☐	☐
Reach above shoulder	☐	☐	☐	☐	☐
Type/keyboard	☐	☐	☐	☐	☐
Joystick/ hand controls	☐	☐	☐	☐	☐
Vibration	☐	☐	☐	☐	☐

Pushing/pulling	**C**	**F**	**O**	**R**	**N**
5 lbs. or less	☐	☐	☐	☐	☐
5–10 lbs.	☐	☐	☐	☐	☐
11–20 lbs.	☐	☐	☐	☐	☐
21–40 lbs.	☐	☐	☐	☐	☐
41–60 lbs.	☐	☐	☐	☐	☐
61-100 lbs.	☐	☐	☐	☐	☐
100+ lbs.	☐	☐	☐	☐	☐
Driving					
Automatic drive	☐	☐	☐	☐	☐
Standard drive	☐	☐	☐	☐	☐

Upper extremities	**Yes**		**No**	
Simple grasping	☐ Right	☐ Left	☐ Right	☐ Left
Pushing/pulling	☐ Right	☐ Left	☐ Right	☐ Left

Operate foot controls	**Yes**		**No**	
	☐ Right	☐ Left	☐ Right	☐ Left
Simultaneous	☐ Yes		☐ No	

Comments

Physician name	Physician telephone
Date released with above restrictions	Date released for full-duty work
Projected date for MMI	Date and time of next appointment
Physician signature	Date