



JCS-Inc. Form

Work Capacities Form

Employee Name: _____ Current Position: _____

Type of Disability: **Physical**
Complete Sections A, C, D, E
(circle one)

Mental
Complete Sections B, C, D, E

Diagnosis: _____

Disability is (circle one): Permanent Temporary

If Temporary estimated
length of disability: _____

Please indicate the level of work that is within this employee's physical and mental capabilities.

Section A Physical Capacities

1. Job Classification - General

- Sedentary Work Lifting 10 pounds maximum
- Light Work Lifting 25 pounds maximum
- Medium Work Lifting 50 pounds maximum
- Heavy Work Lifting 100 pounds maximum
- Very Heavy Work Lifting over 100 pounds

2. Physical Requirements

Key Never: Not at all
Rarely: Occurring during less than 5% of the workday
Occasionally: 6-20% of the workday
Frequently: 21-50% of the workday
Continuously: 51% or more of the workday

	Never	Rarely	Occasionally	Frequently	Continuously
Sit	_____	_____	_____	_____	_____
Stand	_____	_____	_____	_____	_____
Walk	_____	_____	_____	_____	_____
Bend	_____	_____	_____	_____	_____
Crawl	_____	_____	_____	_____	_____
Kneel	_____	_____	_____	_____	_____
Squat	_____	_____	_____	_____	_____
Reach Forward	_____	_____	_____	_____	_____
Twist	_____	_____	_____	_____	_____

Lifting:

	Never	Rarely	Occasionally	Frequently	Continuously
0-10 lbs	_____	_____	_____	_____	_____
11-25 lbs	_____	_____	_____	_____	_____
26-50 lbs	_____	_____	_____	_____	_____
51-100 lbs	_____	_____	_____	_____	_____
100+ lbs	_____	_____	_____	_____	_____

Carrying:

	Never	Rarely	Occasionally	Frequently	Continuously
0-10 lbs	_____	_____	_____	_____	_____
11-25 lbs	_____	_____	_____	_____	_____
26-50 lbs	_____	_____	_____	_____	_____
51-100 lbs	_____	_____	_____	_____	_____
100+ lbs	_____	_____	_____	_____	_____

Manipulation:

	Right		Left	
Simple Grasping	_____ Yes	_____ No	_____ Yes	_____ No
Fine Manipulation	_____ Yes	_____ No	_____ Yes	_____ No
Pushing and Pulling	_____ Yes	_____ No	_____ Yes	_____ No
Repetitive Foot Motions	_____ Yes	_____ No	_____ Yes	_____ No

Section B Mental Capacities

Evaluate each mental activity within the context of the individual's capacity to sustain that activity over a normal workday and workweek, on an ongoing basis.

	Not Limited	Moderately Limited	Markedly Limited
1. Ability to remember locations and work-like procedures	_____	_____	_____
2. Ability to understand and remember short simple instructions	_____	_____	_____
3. Ability to understand and remember detailed instructions	_____	_____	_____
4. Ability carry out short and simple instructions	_____	_____	_____
5. Ability to carry out detailed instructions	_____	_____	_____
6. Ability to maintain attention and concentration for extended periods	_____	_____	_____
7. Ability to perform activities within a schedule, maintain regular attendance, punctuality	_____	_____	_____
8. Ability to sustain an ordinary routine without special supervision	_____	_____	_____
9. Ability to work in conditions with or in proximity to others without being distracted	_____	_____	_____
10. Ability to make simple work-related decisions	_____	_____	_____
11. Ability to complete a normal workday and workweek without interruptions from physiologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods	_____	_____	_____
12. Ability to interact appropriately with the general public	_____	_____	_____
13. Ability to ask simple questions or request assistance	_____	_____	_____
14. Ability to accept instructions and respond appropriately to criticism from supervisors	_____	_____	_____
15. Ability to get along with co-workers or peers without distracting them or exhibiting behavioral extremes	_____	_____	_____
16. Ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness	_____	_____	_____
17. Ability to respond appropriately to changes in the work setting	_____	_____	_____
18. Ability to be aware of normal hazards and take appropriate precautions	_____	_____	_____
19. Ability to travel to unfamiliar places or use public transportation	_____	_____	_____
20. Ability to set realistic goals or make plans independently of others	_____	_____	_____

Section C Comments

Section D Name and Address of Physician completing this form

Physician Signature: _____

Date: _____