ASPEN SNOWMASS

Work Capacity Record

Name: _____ Position: _____

Physician has received and read Employee's Job Description: ☐ Yes ☐ No

WORK STATUS

☐ Return to regular work without restrictions at this time.
☐ Return to modified work on __/__/__ with temporary restrictions/limitations indicated below.
☐ Do not return to work; re-evaluation/follow up as stated below. Unable to work modified job.

MODIFICATIONS FOR WORK AND DAILY LIVING ACTIVITIES

☐ No motor vehicle operation
☐ No skiing/running/jumping
☐ No snowboarding
☐ No bending/twisting from waist
☐ No squatting/pivoting/crawling/kneeling

No repetitive motion of:

Hand Grasp:	☐ Right ☐ Left
Wrist:	☐ Right ☐ Left
Elbow Flexion:	☐ Right ☐ Left
Shoulder:	☐ Right ☐ Left

LIMITATIONS

☐ Work limited to ___hours/day.
☐ Sit down job only.
☐ Walking and standing limited to_____ minutes/hour.
☐ Sitting not to exceed_____ minutes without a 5-minute break to ambulate.
☐ Stooping/bending/twisting. Limited_____ times/hour.
☐ Lifting limited to____ lbs _____times/hour.
☐ Pushing/pulling limited to____ lbs _____times/hour.
☐ OK to walk on level terrain.
☐ OK to ski groomed terrain only.
☐ Other restrictions/comments/recommendations_____
_____

FOLLOW UP

Next appointment scheduled for: _____

Physician's Signature: _____ Date_____
Physician's Name Printed: _____

SIGNATURES

I understand and will abide by these modifications and limitations. *(Supervisor's signature required for modified duty)*

Employee: _____ Supervisor: _____
Date: _____ Date: _____