GEORGIA DEPARTMENT OF HUMAN SERVICES

ATTENDING PHYSICIAN'S STATEMENT OF FUNCTIONAL CAPABILITY

Employee's Name (First/Middle/Last) _____ Social Security # _____

Employee's Street Address _____ City _____ State _____ Zip _____ (____) _____ Employee's Phone Number

Name/Address DHS Facility _____ City _____ State _____ Zip _____

History and Statement of Medical Facts (Physical and Psychological)

A. Date symptoms first appeared/accident occurred _____

B. Date patient ceased work..... _____

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 present active diseases that may affect work activities:

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

	No Limitations	Some Limitations	Avoid Completely	Cannot Determine
Travel: (a) Ability to drive/ride (b)Use of public transportation				
Walk				
Stand				
Sit				
Assume Cramped/Unusual Position				
Reach (forward/overhead)				
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 in Pounds — Frequency: Percentage of Workday

	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.

Yes_____ No_____ Not Determined_____

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

Disability Evaluation	For Current Occupation	For Any Occupation
Patient now totally disabled?	Yes___No____Cannot Determine _____	Yes___No____Cannot Determine_____
If No, when was patient able to resume work activities?	_____Cannot Determine_____	_____Cannot Determine_____
If Yes, when will patient be able to resume work activities?		
Approximate Date	_____0__	_____
Indefinite	_____	_____
Never	_____	_____
Cannot Determine	_____	_____

Progress Evaluation

Recovered	Yes_____No _____	Improved	Yes_____No_____
Unimproved	Yes_____No _____	Retrogressed	Yes_____No_____

Name of Physician — Board Certified Specialty

Street Address — City/Town — State — Zip

(____)_____

Telephone Number — Date — Signature

Revised 9/1/01