Work Capacity Evaluation
Musculoskeletal Conditions

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs

ME-OW

Injured Worker's Name (*First, middle, last*)	OWCP No.	OMB No: 1215-0103 Expires: 08-31-2005

Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions: ______________________

1a. Is the worker capable of performing his/her usual job? ☐ Yes ☐ No. If no, please explain.

Many employers can readily accommodate medical restrictions including assignment of the injured worker into an alternative work location.

b. If the claimant is unable to perform his her usual job, is the claimant able to work for 8 hours per workday with restrictions? ☐ Yes ☐ No. If no, please provide medical reasons to support your opinion. ______________________

c. If less that 8 hour per workday, how many can he/she work? ______________________

d. Do you anticipate an increase in the number of hours this person will be able to work? ☐ Yes ☐ No

e. If yes, when will this person achieve an 8 hour workday? If no, please provide medical reasons to support your opinion ______________________

f. How long will the restrictions apply? ______________________

g. Has maximum medical improvement been reached? ☐ Yes ☐ No.

2. Please indicate whether this person has any **LIMITATION** in the activity listed and how many hours this person can perform each activity. If there are limitations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.

Activity	Limitation	# of Hours Able to Work
Sitting	____ Yes	________
Walking	____ Yes	________
Standing	____ Yes	________
Reaching	____ Yes	________
Reaching above Shoulder	____ Yes	________
Twisting	____ Yes	________
Bending/Stooping	____ Yes	________
Operating Motor Vehicle at work	____ Yes	________
Operating a Motor Vehicle to/from work	____ Yes	________

Activity	Limitation	# of Hours Able to Work	Lbs.
Repetitive Movements:			
Wrists	____ Yes	________	
Elbow	____ Yes	________	
Pushing	____ Yes	________	____
Pulling	____ Yes	________	____
Lifting	____ Yes	________	____
Squatting	____ Yes	________	____
Kneeling	____ Yes	________	____
Climbing	____ Yes	________	____

Breaks:
Duration ____________ Frequency ____________
Duration ____________ Frequency ____________

3. Are there **OTHER** medical facts, situational factors, equipment or devices which need to be considered in the identification of a position for this person? If so, please explain.

4. Physician's Name (*Type or print*)	5. Telephone
6. Signature	7. Date

The information requested will assist OWCP in determining eligibility to benefits and is required to obtain or retain a benefit. (5 USC 8101 et. seq.)

Public Burden Statement

We estimate that it will take an average of 15 minutes per response to complete this information collection including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.