# HENRICO COUNTY PUBLIC SCHOOLS
# PHYSICAL CAPABILITIES FORM

**TO THE PHYSICIAN:** **Modified duty may be provided to this employee. Please provide work restriction information and duration.**

| **PART I. EMPLOYEE INFORMATION** | | |
|---|---|---|
| Employee Name | Injury Date | Today's Date |
| Department or School | Name of Supervisor | Supervisor's Phone # |

| **PART II. TO BE COMPLETED BY PHYSICIAN ONLY** |
|---|
| Complaint(s)/Diagnosis: (Include Part of Body Involved - Left/Right, Upper/Lower) |
| |
| |
| Patient May Return to Work: _____ Regular _____ Restricted (Date: _____) |
| **PATIENT RESTRICTIONS** |
| A. Length of Restriction: (Number of Days) _____ B. Work Restrictions: (Check all that apply) |
| Standing Restrictions: _____ Lifting Restrictions: _____ Bending/stooping restrictions: _____ |
| Pushing/Pulling Restrictions: _____ Sitting Restrictions: _____ Other Restrictions: _____ |
| C. Medication Prescribed: |
| |
| |
| D. Does medication prevent patient from working on or around moving equipment, machinery, driving? Yes _____ No _____ If yes, explain: |
| |
| |
| E. Date of Follow-up Appointment |

| **REFERRAL (If patient is referred to another physician, complete the next line:)** | |
|---|---|
| Date of Appointment | Physician's Name |

| **TREATMENT FACILITY** | | |
|---|---|---|
| Name of Treatment Facility | Address of Treatment Facility | |
| Printed Name of Physician | Signature of Physician | Date |

Submit bills to: Henrico County Risk Management **Department**
**Post Office Box 27032**
**Richmond, Virginina 23072**
(804) 501-5661 FAX: (804) 501-5663

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