

WORK ACCOMMODATION FORM
Employee: _____ **DOB:** _____ **Date:** _____

Patient is released to work as of: Date _____ **WITHOUT Restrictions** **WITH Restrictions stated below**
Return to work program is not appropriate at this time (Please explain): _____

*****PLEASE COMPLETE ENTIRE FORM IF NOT RELEASED TO FULL DUTY*****
Can patient work an eight-hour day? **YES** **NO** – if not, how many hours per day, days per week? _____

Patient can:

Sit	<input type="checkbox"/> 1-3 hours	<input type="checkbox"/> 3-5 hours	<input type="checkbox"/> 5-8 hours
Stand	<input type="checkbox"/> 1-3 hours	<input type="checkbox"/> 3-5 hours	<input type="checkbox"/> 5-8 hours
Walk	<input type="checkbox"/> 1-3 hours	<input type="checkbox"/> 3-5 hours	<input type="checkbox"/> 5-8 hours
Drive	<input type="checkbox"/> 1-3 hours	<input type="checkbox"/> 3-5 hours	<input type="checkbox"/> 5-8 hours
Other	<input type="checkbox"/> Please Explain: _____		

Patient can use hands for repetitive:

Simple Grasping	<input type="checkbox"/> No restriction	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Fine Manipulation	<input type="checkbox"/> No restriction	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Keyboarding	<input type="checkbox"/> No restriction	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Other	<input type="checkbox"/> Please Explain: _____			

Patient is able to:

Bend / Lean	<input type="checkbox"/> No restriction	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Twist	<input type="checkbox"/> No restriction	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Squat	<input type="checkbox"/> No restriction	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Climb	<input type="checkbox"/> No restriction	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Crawl	<input type="checkbox"/> No restriction	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Reach Overhead	<input type="checkbox"/> No restriction	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Other	<input type="checkbox"/> Please Explain: _____			

Patient can lift /carry: No restriction

10 pounds maximum (sedentary)	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Up to 20 pounds maximum (light)	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Up to 50 pounds maximum (medium)	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Over 50 pounds (heavy)	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Never
Other	<input type="checkbox"/> Please Explain: _____		

Push / Pull weight limitations: No restriction 10 lbs 20 lbs 50 lbs OVER 50 lbs Other _____

Patient notified of functional limitations and release date: YES NO

In your estimation, restrictions are: Permanent Temporary until (please provide estimated date): _____

Current degree of disability as it pertains to the injury of this claim, and in accordance with NYS Workers' Compensation Medical Guidelines:

<input type="checkbox"/> None	<input type="checkbox"/> Mild (25%)	<input type="checkbox"/> Moderate (50%)	<input type="checkbox"/> Marked (75%)	<input type="checkbox"/> Total (100%)
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Physician's Printed Name
Physician's Signature
Date
PLEASE FAX RESPONSE TO 585-235-6703. Phone 585-276-5136 for questions. THANK YOU.