STATE OF NEVADA
PHYSICAL ASSESSMENT FORM

To: Treating Physician/Chiropractor
State employees are required to return this form to their supervisor after each medical appointment. Please provide specific information based on your medical findings. An alternative form may be used if it provides the same information.

Patients Name:_________________________ **Claim Number:**_________________________

Agency:_________________________ **Date of Appointment:**_________________________

IN AN 8-10 HOUR DAY (OR LONGER) EMPLOYEE CAN:

Work:	___1-3 hrs	___3-5 hrs	___5-8 hrs	___8-10 hrs	___10+ hrs
Walk:	___1-3 hrs	___3-5 hrs	___5-8 hrs	___8-10 hrs	___10+ hrs
Sit:	___1-3 hrs	___3-5 hrs	___5-8 hrs	___8-10 hrs	___10+ hrs
Stand:	___1-3 hrs	___3-5 hrs	___5-8 hrs	___8-10 hrs	___10+ hrs
Lift:	___Up to 10lbs	___10-20lbs	___20-50lbs	___50 + lbs	

EMPLOYEE IS ABLE TO:

Lift:	___Frequently	___Occasionally	___Not at all
Bend:	___Frequently	___Occasionally	___Not at all
Carry:	___Frequently	___Occasionally	___Not at all
Climb:	___Frequently	___Occasionally	___Not at all
Kneel:	___Frequently	___Occasionally	___Not at all
Reach over shoulders:	___Frequently	___Occasionally	___Not at all

HANDS/WRISTS: Left Right Both

File handling:	___Frequently	___Occasionally	___Not at all	______Wt.
Pushing/Pulling:	___Frequently	___Occasionally	___Not at all	______Wt.
Typing/Keying:	___Frequently	___Occasionally	___Not at all	
Simple Grasping:	___Frequently	___Occasionally	___Not at all	
Fine Manipulation:	___Frequently	___Occasionally	___Not at all	

Safely drive or operate State vehicle at work:		☐Yes ☐No
Safely drive or operate heavy equipment or machinery:		☐Yes ☐No

No inmate confrontations and/or responding to emergencies: _________________________

Other restrictions (or suggested accommodation): _________________________

Has medication been prescribed? ☐ No ☐ Yes What:_________________________

If yes: Can medication be taken while working ☐ No ☐ Yes **– are there any restrictions and if so what:**

Condition stable: ☐ Yes ☐ No **Condition ratable:** ☐ Yes ☐ No
May have suffered a permanent partial disability: ☐ Yes ☐ No

☐ Released to **Full Duty/ No Restrictions** (Date) _________________________

☐ Certified **Totally Temporarily Disabled** (Dates) **From:** ____________ **To:** ____________

☐ Released to **Restricted/Modified Duty** (Date) **From:** ____________ **To:** ____________
Restrictions Are: ☐ **Permanent** ☐ **Temporary**

Date of next appt: ____________ Physician's PRINTED NAME: ____________

Physician's signature: ____________ Date: ____________