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: _____