

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: _____