



County of Henrico, Department of Finance, Risk Management Division

PHYSICAL CAPABILITIES FORM

INJURED EMPLOYEE INFORMATION (To be completed by the employee prior to visit with health care provider)

Full Name: _____

Division/School: _____

Phone: _____ Email: _____

Supervisor's Name: _____ Supervisor's Phone: _____

Type of Health Condition (check one):

Personal (Submit form to supervisor) Date of Injury/Illness: _____

Workers' Compensation (Submit form to supervisor and PMA)
Send forms to PMA by email at claimsmail@pmagroup.com OR fax to 800-432-9762; Questions call 888-954-0866

Workers' Compensation Claim Number: _____ Date of Injury/Illness: _____

PHYSICAL CAPABILITIES (To be completed by health care provider)

Date of Visit: _____ Nature of Injury/Illness: _____

Can the employee return to work?

[] YES, RETURN TO FULL DUTY Date: _____

[] YES, RETURN TO LIGHT DUTY Date: _____ Length of Restrictions: _____

Type of Restrictions (Check all that apply)

- [] Standing (Duration: _____ HRS) [] Sitting (Duration: _____ HRS) [] Walking (Duration: _____ HRS)
[] Lifting, Carrying (Weight: _____ LBS) [] Push/Pull (Weight: _____ LBS) [] Bending/Stooping
[] Other Restrictions (describe in detail):

[] NO, REMAIN OUT OF WORK Length of Restrictions or Anticipated Return to Work Date: _____

Was Medication Prescribed? [] Yes [] No

If YES, does the medication prevent the employee from performing their essential job duties/functions working on or around moving equipment, machinery, or driving? [] Yes [] No

Date of next appointment: _____

Treating Facility: _____ Phone: _____

Treating Facility Address: _____

Treating Physician/Clinician: _____

PRINTED NAME

SIGNATURE