County of Henrico, Department of Finance, Risk Management Division

PHYSICAL CAPABILITIES FORM

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

Employee's Name: _____ Position: _____

Division/School/Station: _____ Shift: _____

Employee's Phone: _____ Employee's 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* Lodestar at **ClaimsMail@Lodestar.com** OR fax to 877-374-0936.
Include Employee's Name and Date of Injury in Subject Line.
Workers' Compensation Claim Number: _____ Date of Injury/Illness: _____

PHYSICAL CAPABILITIES (to be **completed by health care provider**)

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

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

Can the employee return to work?

◯ **YES, Return to REGULAR DUTY without restrictions on date:** _____

◯ **YES, Return to LIGHT DUTY with restrictions on date:** _____ Length of Restrictions: _____

Type of Restrictions (Check all that apply)

◯ Bending/Stooping
◯ Driving (Duration: _____ hours)
◯ Lifting, Carrying (Weight: _____ pounds)
◯ Pushing/Pulling (Weight:_____ pounds)
◯ Sitting (Duration: _____ hours)
◯ Standing (Duration: _____ hours)
◯ Other Restrictions (Describe in detail, include restrictions due to prescribed medication):

◯ **NO, Remain out of work** Length of Restrictions/Anticipated Return to Work Date: _____

Date of next appointment: _____ (Write "NO" if an appointment has not been scheduled.)

Treating Facility: _____

Treating Facility Address: _____ Phone: _____

Treating Physician/Clinician:

Printed Name: _____ Signature: _____