Reset Print

ME-OW

Work Capacity Evaluation
Musculoskeletal Conditions

U.S. Department of Labor
Office of Workers' Compensation Programs

Injured Worker's Name (*First, middle, last*)	OWCP No.	OMB No: 1240-0046 Expires: 10-31-2014

Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions:

1a. Is the worker capable of performing his/her usual job? ☐ Yes ☐ No If no, please explain.

Many employers can readily accommodate medical restrictions including assignment of the injured worker into an alternative work location.

b. If the claimant is unable to perform his her usual job, is the claimant able to work for 8 hours per workday with restrictions? ☐ Yes ☐ No If no, please provide medical reasons to support your opinion.

c. If less that 8 hour per workday, how many can he/she work?

d. Do you anticipate an increase in the number of hours this person will be able to work? ☐ Yes ☐ No

e. If yes, when will this person achieve an 8 hour workday? If no, please provide medical reasons to support your opinion

f. How long will the restrictions apply?

g. Has maximum medical improvement been reached? ☐ Yes ☐ No

2. Please indicate whether this person has any **LIMITATION** in the activity listed and how many hours this person can perform each activity. If there are limitations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.

Activity	Limitation	# of Hours Able to Work
Sitting	☐ Yes	
Walking	☐ Yes	
Standing	☐ Yes	
Reaching	☐ Yes	
Reaching above Shoulder	☐ Yes	
Twisting	☐ Yes	
Bending/Stooping	☐ Yes	
Operating Motor Vehicle at work	☐ Yes	
Operating a Motor Vehicle to/from work	☐ Yes	

Activity	Limitation	# of Hours Able to Work	Lbs.
Repetitive Movements:			
Wrists	☐ Yes		
Elbow	☐ Yes		
Pushing	☐ Yes		
Pulling	☐ Yes		
Lifting	☐ Yes		
Squatting	☐ Yes		
Kneeling	☐ Yes		
Climbing	☐ Yes		
Breaks:			
Duration		Frequency	
Duration		Frequency	

3. Are there **OTHER** medical facts, situational factors, equipment or devices which need to be considered in the identification of a position for this person? If so, please explain.

4. Physician's Name (*Type or print*)	5. Telephone Number (Include Area Code)
6. Signature	7. Date

Privacy Act Statement

The Privacy Act of 1974 as amended (5 U. S.C. 552a) and the Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.), authorizes collection of this information. The purpose of this form is to obtain the claimant's specific work tolerance limitation where the accepted condition is musculoskeletal in nature. Completion of this form is voluntary (5 U.S.C. 8101, et seq), however, failure to provide the information may result in the delay of processing of the claim or payment or benefits, or may result in an unfavorable decision or reduced levels of benefits. Additional disclosures of this information may be to: third parties in litigation; employing agencies, various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to this collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain a benefit under 5 U.S.C. 8101, et seq. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210, and reference the OMB Control Number 1240-0046. Note: Please do not return the requested information to the address shown just above. Rather, send it to the address shown on the letterhead.

Notice

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or the claims examiner to ask about this assistance.