5 South Last Chance Gulch
P.O. Box 4759
Helena, MT 59604-4759
Phone: 406-444-6500
Fax: **406-444-5963**
www.montanastatefund.com

WORK CAPACITY

Name of Physician: ______________________________

Date of Exam: ______________________________

PATIENT INFORMATION

Patient's Name (Please Print)______________________________ Claim Number ______________________

Social Security Number ______________________________ Date of Birth ______________________

PROVIDER MUST COMPLETE THIS SECTION OF THE FORM

Is the worker medically stationary (MMI)? Yes ____No ____Date:__________ Anticipated Date of MMI: ____________

Impairment Rating: Yes ___No ___ Rating:____________ /or/ Anticipated Impairment Rating: ________________

DISPOSITION
Check only one

☐ Release with no restrictions (date) ______________________________

☐ Patient may not work until (date) ______________________________

☐ Restricted duty until (date) ______________________________

PROVIDER MUST COMPLETE SECTION BELOW WHEN RESTRICTED DUTY IS IDENTIFIED

Because of the nature of injury, the worker is released with the following range of restriction to return to work:

- - - - - - Lift / Carry / Push / Pull - - - - - - -

Frequency	N.A.	0-10 #s	10-25 #s	25-50 #s	>50 #s
Never					
Occasionally					
Frequently					

Activity	N.A.	Never	Occasionally	Repetitively
Bend				
Squat				
Climb				
Crawl				

Restriction	N.A.	Never	Permitted, but limited to:
Standing			☐ 2 hours ☐ 4 hours ☐ 6 hours
Sitting			☐ 2 hours ☐ 4 hours ☐ 6 hours
			☐ Alternate Sitting or Standing for ____ minutes for ____ hours per day.

REPETITIVE: Repetitive grasping / holding / manipulating with right / left /either hand limited to:

____
____
____
____

MOTION: Repetitive reaching above shoulder height with right / left / either arm limited to:

____
____
____
____

Comments

FOLLOW-UP: Surgery ______________________________ Date:______________
Referred to ______________________________ Date:______________

NEXT SCHEDULED APPOINTMENT DATE: ________________

Provider's Signature______________________________ **Date:**____________________

Provider's Federal Tax ID #______________________________

Please Fax this Form to (406) 444-5963 or Mail to P.O. Box 4759 – Helena, MT 59604-4759