

**\*\*To be completed before employee can return to work**

**BANDERA COUNTY**  
**PHYSICAL CAPABILITIES**

\_\_\_\_\_ has been under my care since \_\_\_\_\_. As a result of his most recent examination the following limitation(s) are prescribed:

In a 12-hour shift, the employee can stand/walk \_\_\_\_\_ hours at one time, \_\_\_\_\_ total hours during the day or \_\_\_\_\_ no restrictions.

In a 12-hour shift, the employee can sit \_\_\_\_\_ hours at one time, \_\_\_\_\_ total hours during the day or \_\_\_\_\_ no restrictions.

In a 12-hour shift, the employee can drive \_\_\_\_\_ hours at one time, \_\_\_\_\_ total hours during the day or \_\_\_\_\_ no restrictions.

Employee can lift or carry:

Maximum lbs.: 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

Frequently or occasionally

Employee can use his hands for repetitive

Simple Grasping \_\_\_\_\_ YES or \_\_\_\_\_ NO

Pushing and Pulling \_\_\_\_\_ YES or \_\_\_\_\_ NO

Fine Manipulation \_\_\_\_\_ YES or \_\_\_\_\_ NO

Employee can use feet for repetitive operation of foot controls

\_\_\_\_\_ YES      \_\_\_\_\_ NO      \_\_\_\_\_ No Restrictions

Employee is able to:    Frequently    Occasionally    Not At All

Bend  
Squat  
Kneel  
Climb  
Reach

When do estimate the employee can be released to return to work at

Limited Duty \_\_\_\_\_ Length of Restrictions \_\_\_\_\_

Full Duty \_\_\_\_\_

Additional Comments:

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_