

## RELEASE OF INFORMATION

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_, physician/  
(Please PRINT) (Please PRINT)  
practitioner, to furnish written information to \_\_\_\_\_,  
my employer, regarding my residual functional capacity, any limitations or restrictions on my ability to  
perform the functions of my position and any devices, equipment, or accommodations I require to enable  
me to perform these functions.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

## FUNCTIONAL CAPACITY ASSESSMENT

Physician/Practitioner - Please confine your completion of this form to only those elements that are  
pertinent to the employee's ability to perform the essential functions of his/her job. Explain any limitations  
in Section G.

### Genetic Information Nondiscrimination Act of 2008 Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities  
covered by GINA Title II from requesting or requiring genetic information of an individual or family  
member of the individual, except as specifically allowed by this law. To comply with this law, we are  
asking that you not provide any genetic information when responding to this request for medical  
information. "Genetic Information" as defined by GINA includes an individual's family medical history, the  
results of an individual's or family member's genetic tests, the fact that an individual or an individual's  
family member sought or received genetic services, and genetic information of a fetus carried by an  
individual or an individual's family member or an embryo lawfully held by an individual or family member  
receiving assistive reproductive services.

### A. POSTURAL LIMITATIONS:

	Continuously (4-6 hrs./day)	Frequently (2-6 hrs./day)	Infrequently (0-2 hrs./day)	Never
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting/Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### B. PHYSICAL EXERTION LIMITATIONS:

	Up to 10 lbs.	10 lbs. to 25 lbs.	25 lbs. to 50 lbs.	Over 50 lbs.
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C. MANIPULATIVE LIMITATIONS:**

	Unlimited	Limited
Handling (gross)	<input type="checkbox"/>	<input type="checkbox"/>
Fingering (fine)	<input type="checkbox"/>	<input type="checkbox"/>
Feeling (skin receptors)	<input type="checkbox"/>	<input type="checkbox"/>

**D. MENTAL LIMITATIONS:**

	Unlimited	Limited
Understanding	<input type="checkbox"/>	<input type="checkbox"/>
Remembering	<input type="checkbox"/>	<input type="checkbox"/>
Sustained concentration	<input type="checkbox"/>	<input type="checkbox"/>
Following through on instructions	<input type="checkbox"/>	<input type="checkbox"/>
Decision making	<input type="checkbox"/>	<input type="checkbox"/>
Responding appropriately to workplace pressures	<input type="checkbox"/>	<input type="checkbox"/>
Receiving supervision	<input type="checkbox"/>	<input type="checkbox"/>
Relating to co-workers	<input type="checkbox"/>	<input type="checkbox"/>

**E. VISUAL/COMMUNICATIVE LIMITATIONS:**

	Unlimited	Limited
Acuity (near/far); Depth; Color; Field	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Speaking	<input type="checkbox"/>	<input type="checkbox"/>

**F. NON-PHYSICAL EXERTION LIMITATIONS:**

Pain (frequency; degree; objective signs)

Environmental restrictions (exposure to dust, fumes, smoke, heights, heat/cold, noise; other)

Rest periods (frequency/duration)

Side effects of medication

**G. REMARKS:**

(Please use this space to explain or clarify any of the preceding information.) Describe any specific limitations or restrictions for any of the above categories and list any assistive devices, equipment, or accommodation the employee requires to perform his or her job:

---

Physician's/Practitioner's Signature

---

Date

---

Name of Practice

---

Type of Practice

---

Address

---

Telephone