UNIVERSITY of HAWAI'I® SYSTEM

OFFICE OF HUMAN RESOURCES
2440 CAMPUS ROAD, ADMINSTRATIVE SERVICES BLDG 2
HONOLULU, HAWAII 96822

RE:
Employer:
DOI:
Case No.:

ESTIMATED FUNCTIONAL CAPACITY EVALUATION FORM

1. Please indicate physical limitations:

Percent of the Day:		**Never (0%)**	**Occasional (1-33%)**	**Frequent (34-66%)**	**Unrestricted (67-100%)**
LIFTING:					
Sedentary	1-10	☐	☐	☐	☐
Light	11-25	☐	☐	☐	☐
Medium	26-50	☐	☐	☐	☐
Heavy	50-100	☐	☐	☐	☐
	Pounds				
CARRYING:	1-10	☐	☐	☐	☐
	11-25	☐	☐	☐	☐
	26-50	☐	☐	☐	☐
	50-100	☐	☐	☐	☐
	pounds				
SITTING:		☐	☐	☐	☐
STANDING:		☐	☐	☐	☐
WALKING:		☐	☐	☐	☐
RUNNING:		☐	☐	☐	☐
STAIR CLIMBING:		☐	☐	☐	☐
LADDER CLIMBING:		☐	☐	☐	☐
BENDING:		☐	☐	☐	☐
CRAWLING:		☐	☐	☐	☐
SQUATTING:		☐	☐	☐	☐
KNEELING:		☐	☐	☐	☐
STOOPING:		☐	☐	☐	☐
CROUCHING:		☐	☐	☐	☐
FORWARD REACHING:		☐	☐	☐	☐
TWISTING:		☐	☐	☐	☐
SIDE BENDING:		☐	☐	☐	☐
OVERHEAD REACH:		☐	☐	☐	☐

1. **Please indicate physical limitations:**

Percent of the Day:	**Never (0%)**	**Occasional (1-33%)**	**Frequent (34-66%)**	**Unrestricted (67-100%)**
HAND RESTRICTIONS:				
GRASPING:	☐	☐	☐	☐
HANDLING:	☐	☐	☐	☐
FINGERING:	☐	☐	☐	☐
PUSHING:	☐	☐	☐	☐
PULLING:	☐	☐	☐	☐

2. **Patient can use feet for repetitive movement as in operating foot controls:**

Right Foot	Left Foot	Both Feet
No ☐ Yes ☐	No ☐ Yes ☐	No ☐ Yes ☐

3. **Can patient operate a car, truck, crane, tractor, or other type of motor vehicle?**

   No ☐ Yes ☐

4. **Are there cardiac, visual or hearing limitations?**

   No ☐ Yes ☐ *If YES please explain:*

5. **Are there restrictions concerning heat, cold, dampness, height, temperature changes, high speed working, or exposure to dust, fumes or gases?**

   No ☐ Yes ☐ *If YES please explain*:

6. **Are interpersonal relations affected because of a neuropsychiatric condition?**

   No ☐ Yes ☐ *If YES please explain:*

7. Can **the individual work eight hours a day? If not eight hours/how many?**_____
   Start Date:_____
   No ☐ Yes ☐ *If YES indicate when:*

8. **Has the individual reached maximum improvement?**

   ☐ YES *(Indicate when)*_____ ☐ NO

9. **Are listed restrictions (check one only)** ☐ **PERMANENT** ☐ **TEMPORARY**

Please specify any additional recommendations/comments you have regarding patient's limitations (i.e. restrictions from medication or other limitations):

_____ _____

Physician's Signature Date