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State of Vermont
Department of Labor
Workers' Compensation Division
PO Box 488
Montpelier, VT 05601-0488
(802) 828-2286

Form 20 Rev. 12/10

State File No.**: _____
Ins. Co. File No.: _____
Date of Injury: _____

Work Capabilities Form

Form recommended for use by medical providers in assessing work capabilities of patients with work injuries

Employee's Name: _____ Based on my examination of this patient on: _____

☐ May **Return to Work** with **NO RESTRICTIONS**
☐ May **Return to Work** on _____ with the following capabilities:

Stand/Walk:
☐Not at all ☐1-3 hours ☐3-5 hours ☐5-8 hours ☐Unrestricted

Sit:
☐Not at all ☐1-3 hours ☐3-5 hours ☐5-8 hours ☐Unrestricted

Drive:
☐Not at all ☐1-3 hours ☐3-5 hours ☐5-8 hours ☐Unrestricted

Lift:
☐Not at all
☐No more than **10** lbs. ☐Occasionally ☐Frequently
☐No more than **20** lbs. ☐Occasionally ☐Frequently
☐No more than **50** lbs ☐Occasionally ☐Frequently
☐No more than **100** lbs. ☐Occasionally ☐Frequently
☐Unrestricted

Bend:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Squat:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Climb:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Twist:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Reach above shoulders:
☐Not at all ☐Occasionally ☐Frequently ☐Unrestricted

Specific work capabilities not listed above: _____

Employee has limited use of: _____

Employee ☐can ☐cannot perform repetitive activities for more than _____ min/hrs.

Employee ☐can ☐cannot work more than 8 hours a day.

Work capabilities are in effect until: _____ ; or ☐until further evaluation.

☐ May **NOT RETURN TO WORK** Estimated duration of total disability: _____

Scheduled for a follow-up appointment on: _____

Referred to: _____ for follow-up care.

_____ _____
Medical Provider's Name (Print) Date

_____
Medical Providers Signature

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this medical provider to release any information acquired in the course of my examination or treatment for the above injury to my employer or its representative.

Patient Signature: _____ Date: _____

** If you do not have the state file number please contact the Department of Labor at (802) 828-2286.