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ME-OW

Work Capacity Evaluation
Cardiovascular/Pulmonary Conditions

U.S. Department of Labor
Office of Workers' Compensation Programs

Injured Worker's Name (*First, middle, last*) *	OWCP No. *	OMB No: 1240-0046 Expires: 09/30/2011

Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions:

1.a. Is this employee capable of performing his/her usual job? Yes No. If no, is **prevention** (of possible future injury) the **only reason** for work limitations? Yes No. **If prevention is not the only reason,** please explain your medical reason for limitations: *

Many employers can readily accommodate medical restrictions including assignment of the injured worker to an alternative work location.

b. If unable to perform his/her usual job, is the employee able to work for 8 hours per workday with restrictions?

c. If less than 8 hours per workday, how many hours can he/she work?

d. Do You anticipate an increase in the number of hours this person will be able to work? Yes No

If yes, when will this person achieve an 8 hour workday?

If no, please provide medical reasons to support your opinion:

2. Has the work injury/condition caused **ANATOMICAL** and/or **FUNCTIONAL** changes in the cardiovascular or respiratory systems that preclude exposure to: *

a. Temperature extremes	Yes	No	c. Gas/fumes	Yes	No
b. Airborne particles	Yes	No	d. Electromagnetic radiation	Yes	No

3. Please indicate whether this person has any **LIMITATION** in the activity listed and how many hours this person can perform each activity. If there are limitations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.

Activity	Limitation	# of Hours Able to Work	Activity	Limitation	# of Hours Able to Work	Lbs.
Sitting	Yes		Pushing	Yes		
Walking	Yes		Pulling	Yes		
Standing	Yes		Lifting	Yes		
Reaching	Yes		Squatting	Yes		
Bending	Yes		Kneeling	Yes		
Operating a Motor Vehicle	Yes		Climbing	Yes		

4. Is the person taking **MEDICATIONS** that impact the ability to work? Please explain. *

5. Are there OTHER medical factors, situational considerations (e.g., high volume work, shifting priorities), equipment or devices which need to be considered in the identification of a position for this person? If so, please explain.

6. Physician's Name (*Type or print*) *	7. Telephone *

8. Signature *	9. Date *
Signature	

The information requested will assist OWCP in determining eligibility to benefits and is required to obtain or retain a benefit. (5 USC 8101 et. seq.)

Public Burden Statement

We estimate that it will take an average of 15 minutes per response to complete this information collection including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

DO *NOT* SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.

OWCP 5b:

PRIVACY ACT

"NOTE: The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is Section 8101, et seq., Title 5 of the U.S. Code authorizes collection of this information. **Completion of this form is required for the claimant to obtain or retain a benefit under 5 U.S.C. 8101** et seq. The information is used to obtain the claimant's specific work tolerance limitations where the accepted condition is cardiovascular or pulmonary in nature. Additional disclosures of this information may be to: third parties in litigation; employing agencies, various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus."