

PHYSICAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT






CLAIMANT:		SOCIAL SECURITY NUMBER:	
NUMBERHOLDER (IF CDB CLAIM):		- -	
PRIMARY DIAGNOSIS:	RFC ASSESSMENT IS FOR:		
SECONDARY DIAGNOSIS:	<input type="checkbox"/> Current Evaluation	<input type="checkbox"/> Date	12 Months After Onset:
OTHER ALLEGED IMPAIRMENTS:	<input type="checkbox"/> Date Last Insured: _____	(Date)	(Date)
	<input type="checkbox"/> Other (Specify): _____		

PRIVACY ACT NOTICE: The information requested on this form is authorized by Section 223 and Section 1633 of the Social Security Act. The information provided will be used in making a decision of this claim. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal laws requiring the exchange of information between Social Security and other agencies.

SEE REVISED PRA, ATTACHED
PAPERWORK REDUCTION ACT: This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.

I. LIMITATIONS:

For Each Section A - F

-  Base your conclusions on **all evidence** in file (clinical and laboratory findings; symptoms; observations, lay evidence; reports of daily activities; etc.).
-  Check the blocks which reflect your **reasoned judgement**.
-  Describe how the **evidence substantiates your conclusions** (Cite specific clinical and laboratory findings, observations, lay evidence, etc.).
-  Ensure that you have:
 - Requested appropriate treating and examining source statements regarding the individual's capacities (DI 22505.000ff. and DI 22510.000ff.) and that you have given appropriate **weight to treating source conclusions** (See Section III.).
 - Considered and responded to **any alleged limitations imposed by symptoms** (pain, fatigue, etc.) attributable, in your judgement, to a medically determinable impairment. Discuss your assessment of symptom-related limitations in the explanation for your conclusions in A - F below (See also Section II.).
 - Responded to all allegations of physical limitations or factors which can cause physical limitations.
-  **Frequently** means occurring one-third to two-thirds of an 8-hour workday (cumulative, not continuous). **Occasionally** means occurring from very little up to one-third of an 8-hour workday (cumulative, not continuous).

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A. EXERTIONAL LIMITATIONS

None established. (Proceed to section B.)

1. **Occasionally** lift and/or carry (including upward pulling)
(maximum) - when less than one-third of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

- less than 10 pounds
- 10 pounds
- 20 pounds
- 50 pounds
- 100 pounds or more

2. **Frequently** lift and/or carry (including upward pulling)
(maximum) - when less than two-thirds of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

- less than 10 pounds
- 10 pounds
- 25 pounds
- 50 pounds or more

3. Stand and/or walk (with normal breaks) for a total of -

- less than 2 hours in an 8-hour workday
- at least 2 hours in an 8-hour workday
- about 6 hours in an 8-hour workday
- medically required hand-held assistive device is necessary for ambulation

4. Sit (with normal breaks) for a total of -

- less than about 6 hours in an 8-hour workday
- about 6 hours in an 8-hour workday
- must periodically alternate sitting and standing to relieve pain or discomfort. (If checked, explain in 6.)

5. Push and/or pull (including operation of hand and/or foot controls) -

- unlimited, other than as shown for lift and/or carry
- limited in upper extremities (describe nature and degree)
- limited in lower extremities (describe nature and degree)

6. Explain how and why the evidence supports your conclusions in item 1 through 5.
Cite the specific facts upon which your conclusions are based.

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B. POSTURAL LIMITATIONS

None established. (Proceed to section C.)

	Frequently	Occasionally	Never
1. Climbing - ramp/stairs _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- ladder/rope/scaffolds _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Balancing _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Stooping _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Kneeling _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Crouching _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Crawling _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. When less than two-thirds of the time for frequently or less than one-third for occasionally, fully describe and explain. Also explain how and why the evidence supports your conclusions in items 1 through 6. Cite the specific facts upon which your conclusions are based.

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C. MANIPULATIVE LIMITATIONS

None established. (Proceed to section D.)

- | | LIMITED | UNLIMITED |
|---|----------------------------|--------------------------|
| 1. Reaching all directions (including overhead) _____ | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Handling (gross manipulation) _____ | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Fingering (fine manipulation) _____ | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Feeling (skin receptors) _____ | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Describe how the activities checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions in item 1 through 4. Cite the specific facts upon which your conclusions are based. | | |

D. VISUAL LIMITATIONS

None established. (Proceed to section E.)

- | | LIMITED | UNLIMITED |
|--|----------------------------|--------------------------|
| 1. Near acuity _____ | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Far acuity _____ | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Depth perception _____ | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Accommodation _____ | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Color vision _____ | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Field of vision _____ | ▶ <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Describe how the faculties checked "limited" are impaired. Also explain how and why the evidence supports your conclusions in items 1 through 6. Cite the specific facts upon which your conclusions are based. | | |

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E. COMMUNICATIVE LIMITATIONS

None established. (Proceed to section F.)

	LIMITED	UNLIMITED
1. Hearing _____ →	<input type="checkbox"/>	<input type="checkbox"/>
2. Speaking _____ →	<input type="checkbox"/>	<input type="checkbox"/>

3. Describe how the faculties checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions in items 1 and 2. Cite the specific facts upon which your conclusions are based.

F. ENVIRONMENTAL LIMITATIONS

None established. (Proceed to section II.)

	UNLIMITED	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
1. Extreme cold _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Extreme heat _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Wetness _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Humidity _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Noise _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Vibration _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Fumes, odors, dusts, gases, poor ventilation, etc. _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Hazards (machinery, heights, etc.) _____ →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Describe how these environmental factors impair activities and identify hazards to be avoided. Also, explain how and why the evidence supports your conclusions in items 1 through 8. Cite the specific facts upon which your conclusions are based.

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II. SYMPTOMS

For symptoms alleged by the claimant to produce physical limitations, and for which the following have not previously been addressed in section I, discuss whether:

- A. The symptom(s) is attributable, in your judgment, to a medically determinable impairment.
- B. The severity or duration of the symptom(s), in your judgment, is disproportionate to the expected severity or expected duration on the basis of the claimant's medically determinable impairment(s).
- C. The severity of the symptom(s) and its alleged effect on function is consistent, in your judgment, with the total medical and nonmedical evidence, including statements by the claimant and others, observations regarding activities of daily living, and alterations of usual behavior or habits.

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III. TREATING OR EXAMINING SOURCE STATEMENT(S)

A. Is a treating or examining source statement(s) regarding the claimant's physical capacities in file?

Yes

No (Includes situations in which there was no source or when the source(s) did not provide a statement regarding the claimant's physical capacities.)

B. If yes, are there treating/examining source conclusions about the claimant's limitations or restrictions which are significantly different from your findings?

Yes

No

C. If yes, explain why those conclusions are not supported by the evidence in file. Cite the source's name and the statement date.

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IV. ADDITIONAL COMMENTS:

THESE FINDINGS COMPLETE THE MEDICAL PORTION OF THE DISABILITY DETERMINATION.

MEDICAL CONSULTANT'S SIGNATURE:

MEDICAL CONSULTANT'S CODE: DATE:

The following revised PRA Statement will be inserted into the form at its next scheduled reprinting:

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*