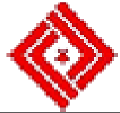
Work Capacity Evaluation
Psychiatric/Psychological Conditions

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

ME-OW



Injured Worker's Name (*First, middle, last*)	OWCP No.	OMB No: 1215-0103 Expires: 10/31/2008

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

1. Is the employee competent to WORK 8 hours a day? If no, your medical reasons are required to support your opinion.

2. If the employee is unable to work 8 hours a day, how many hours is he/she able to work?

   a. Will the number of hours increase? ☐ Yes ☐ No
   b. If yes, when will this employee be able to work eight hour work days?
   c. If no, your medical reasons are required to support your opinion.

3. Is the worker competent to perform his/her usual job? ☐ Yes ☐ No If no, specify which aspects of the position are problematic. An explanation is required for each item.

4. OWCP is committed to reemploying injured workers to the fullest extent possible. Many employers can readily accommodate medical restrictions including assignment of the injured worker into an alternative work location. Please note that if reemployment at the employing agency is not possible, the Office may pursue vocational rehabilitation for the injured worker. With this in mind, please describe the duties or work environment(s) which are suitable for your patient. Please be as detailed as possible.

5. Please list, if any, other medical factors which need to be considered in the identification of a position for this person. Please explain each item.

6. Physician's Name (*Type or print*)	7. Telephone
8. Signature	9. Date

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 THIS OFFICE

OWCP 5a:

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 where the accepted condition is psychiatric or psychological 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."