# Work Capacity Evaluation Cardiovascular/Pulmonary Conditions

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

**ME-OW** 

injured Vocker's Name (First, middle, isst)       OWD Rot.       OMB Rot. 1240.0046         Please answer the quastions below concerning your patient (named above) for whom the Office of Worker's Compensation Programs (OWCP) has accepted the following conditions.       Express: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX			1		Allis Of
Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (CWCP) has accepted the following contributions          1.a. Is this employee capable of performing hisher usual job without testificiton?       Yes       No. If no, is prevention (of possible future injury) the only reason for work inflations of work inflations of work inflations of work inflations of yes       No. If no, is prevention (of possible future injury) the only reason for work inflations of the only reason. Figure explain your medical reason to support or your collision in a medical report.         b. if unable to perform hisher usual job, is the employee able to work for 8 hours per workday. Now many hours on heshe work?       Yes       No         c. if less that four usual job, is the employee able to work?       Yes       No       No         d. Do You antiopher an increase in the number of hours this parsace wills packle to work?       Yes       No         if less that points perform hisher usual job, is the employee able to work?       Yes       No       C Gastfures         if yes, when whit is person on an endical report       .       No       C Gastfures       No         a. Temperature externes       Yes       No       C Gastfures       No       No         a. Temperature externes       Yes       No       C Gastfures       No       No         a. Temperature externes       Yes	Injured Worker's Name ( First, middle, last )		OWCP No.		OMB No: 1240-0046
accepted the following conditions         1.a. Is this employee capable of performing hisher usual job without restriction?       \no. If no, is prevention (of possible future injury)         the only reason for work limitations?       \no. If prevention is a metabolic report.         Many employers can readily accommodate medical restrictions including assignment of the injured worker to an alternative work location.         b. If unbit to perform hisher usual job, is the employee able to work for 8 hours per workday with physical restrictions?         c. If less than 8 hours per workday, how many hours can heather work?       Yes         b. If unbits to perform hisher usual job, is the employee able to work for 8 hours per workday with physical restrictions?       .         c. If less than 8 hours per workday, how many hours can heather work?       Yes       No         d. Do You antibute an increase in the number of hour opfinion in a medical report?       .       .         a. Temporther extremes       \no.       c. Gas/furnes       \no.         a. Temporther work individual caused ANATOMICAL and/or FUNCTIONAL changes in the cardiovascular or reprintory system that preclude exposure to:       a.       .         a. Temporther the Guidance for Physicians induction pages 2 and 3 of this form. Bazed on the parameter mediate whether this person an arefform each workly. If there an innitions in itting, pulling and/or pushing. Pages provide the maximum number of pounds mat can be handred by this person.       See of Hours Alte to Work Losthere and innition Alternet by the inductive					Expires: XX-XX-XXXX
accepted the following conditions         1.a. Is this employee capable of performing hisher usual job without restriction?       Yes       No       If no, is prevention (of possible future injury)         the only reason for work limitations?       Yes       No       If no, is prevention (of possible future injury)         the initiations:       war ophion in a medical restrictions including assignment of the injured worker to an alternative work location.         b. If unble toefform hisher usual job, is the employee able to work for 8 hours per workday with physical restrictions?					
1.a. Is this employee capable of performing his/her usual job without restriction?       Yes       No       If prevention is not the only reason, Diease explain your medical reason to support your opnicon in a medical resort.         Many employers can readily accommodate medical restrictions including assignment of the injured worker to an alternative work flocation.       If analy the perform his/her usual job, is the employee able to work?       Yes       Image: State in the employee able to work?       Yes       No         0. You anticipate an increase in the emptory to those the perform his/her usual job, is the employee able to work?       Yes       No       No       Yes       No         1.4. Be the work injuny/condition caused ANATOMICAL and/or FUNCTIONAL changes in the cardiovascular or respiratory systems that perform his/her usual point on the approximation and the following Strength Levels:       No       C cast/unless       Yes       No         2. Has the work injuny/condition caused ANATOMICAL and/or FUNCTIONAL changes in the cardiovascular or respiratory systems that perform his/in using Strength Levels:       No       C cast/unles       Yes       No         3. Altorne particles       Yes       No       d Electromagnetic radiation       Yes       No         3. Altorne particles       Yes       No       d Electromagnetic radiation       Yes       No         3. Altor prevent the Guidance for Physicians included on pages 2 and 3 of this form. Based on thow many hourus this person and the the following With any of the		our patient (named abo	ve) for whom the Office of	r Workers' Compensatio	on Programs (OWCP) has
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for limitations:       vour opinion in a medical report.         Many employers can readily accommodate medical restrictions including assignment of the injured worker to an alternative work location.         b. If unable to perform hisher susal job, is the employee able to work for 8 hours per workday with physical restrictions?         c. If less than 8 hours per workday, how many hours can hesher work?       Yes         d. Do You antiogate an increase in the number of hours this person antibe able to work?       Yes         if no, please provide middle measons to support your collinon in a medical report.       .         2. Has the work injurylcondition caused ANATOMICAL and/or FUNCTIONAL changes in the cardiovascular or respiratory systems that preclude exposure to:       a. Temperature extremes       Yes       No         a. Temperature extremes       Yes       No       c. Casifumes       Yes       No         3a. Please review the Guidance for Physicians included on page 2 and 3 of this form. Based on the parameters provided, please indicate whether this person has any to use the looking Storing threave:       No       West       No         3b. If not, please indicate whether this person has any to use an maximum number of pounds that can be handled by this person.       # of Hours       # of Hours         Activity       Limitation       Able to Work       Limitation       # of Hours         Stiting       Yes       Pushing       Yes       Pushing	the <b>only reason</b> for work limitations? Yes	□ <sub>No</sub> If prevention	is not the only reason,		
Many employers can readily accommodate medical restrictions including assignment of the injured worker to an alternative work location.         b. If unable to perform higher usual job, is the employee able to work for 8 hours per workday, how many hours can heistee work?		your opinion ir	n a medical report.		
alternative work location.         b. If unable to perform hisher usual job, is the employee able to work for <u>6 hours per workday</u> with physical restrictions?         c. If less than bours per workday, how may hours can he/she work?         g. Do You anticipate an increase in the number of hours this person and perform workday         if hos, than bours per workday, how may hour softway         if hos, please provide medical reasons to support your opnion in a medical report.         2. Has than work injury/condition caused ANATOMICAL and/or FUNCTIONAL changes in the cardiovascular or respiratory systems that preclude exposure to:         a. Temperature externes       Yes         Yes       No         c. Gas/fumes       Light Yes         No       C. Bectromagnetic radiation         is capable of working within any of the following Strength Levels:       Sedentary         Yes       No         3b. If not, please indicate whether this person has any LIMITATION in the activity listed and how mary hours this person.       # of Hours         Activity       Limitation       # of Hours         Activity       Limitation       # of Hours         Activity       Limitation       # of Hours         Sting       Yes       Was         Bob of working within any of the following Strength Levels:       Activity         Store the seton distate whether this person has any LIM					
alternative work location.         b. If unable to perform hisher usual job, is the employee able to work for <u>8 hours per workday</u> with physical restrictions?         c. If less than bours per workday, how may hours can he/she work?         West han bours per workday.         If hours perform his are provide medical reasons to support your opnion in a medical report!         2. Has the work injury/condition caused ANATOMICAL and/or FUNCTIONAL changes in the cardiovascular or respiratory systems that period exposure to: <ul> <li>a. Temperature extremes</li> <li>Yes</li> <li>No</li> <li>c. Gas/fumes</li> <li>Light   Yes</li> <li>No</li> <li>d. Electromagnetic radiation</li> <li>Yes</li> <li>No</li> <li>Light   Yes</li> <li>No</li> </ul> 3a. If not, please indicate whether this person has any LIMITATION in the activity listed and how many hours this person. <li># of Hours</li> <li>Activity</li> <li>Limita</li>					
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b. If unable to perform his/her usual job, is the employee able to work for 8 hours per workday with physical 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   How hill this person achieve an 8 hour workday?   2. Has the work injury/condition caused ANATOMICAL and/or FUNCTIONAL changes in the cardiovascular or respiratory systems that preclude exposure to: <ul> <li>a. Temperature extremes</li> <li>Yes</li> <li>No</li> <li>d. Electromagnetic radiation</li> <li>Yes</li> <li>No</li> <li>d. Electromagnetic radiation</li> <li>Yes</li> <li>No</li> </ul> 3a. Please review the Guidance for Physicians included on pages 2 and 3 of this form. Based on the parameters provided, please indicate whether this person is capable of working within any of the following Strength Levels: <ul> <li>Section 1</li> <li>Yes</li> <li>No</li> <li>Heavy</li> <li>Yes</li> <li>Heavy</li> <li>Yes</li> <li>No</li> <li>Heavy</li> <li>Yes</li> <li>Heavy</li> <li>Yes</li></ul>		nodate medical re	strictions including	assignment of th	ie injured worker to an
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 <u>person will be</u> able to work? Yes No Yes, Haw will his person achieve an 8 hour workday/ I'no, please provide medical reasons to support your ophion in a medical report 2. Has the work injurylcondition caused <b>ANATOMICAL</b> and/or <b>FUNCTIONAL</b> changes in the cardiovascular or respiratory systems that preclude exposure to: a. Temperature extremes Yes No C. Gas/Jumes C	alternative work location.				
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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 in a medical report!					
If yes, when will this person achieve an 8 hour workday?				Yes No	
If no, please provide medical reasons to support your opinion in a medical report:         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/furmes       Yes       No         3a. Please review the Guidance for Physicians included on pages 2 and 3 of this form. Based on the parameters provided, please indicate whether this person is capabile of working within any of the following Strength Levies:       Sedentary       Yes       No       Light ("Yes")       No         3b. If not, please indicate whether this person has any LIMITATION in the activity listed and how many hours his person can perform each activity. If there are initiations in litting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.       # of Hours         Activity       Limitation       # of Hours       # of Hours       # of Hours         Activity       Limitation       # of Hours       # of Hours       # of Hours         Waiking       Yes       Pushing       Yes       Pushing       # or Hours         Waiking       Yes       Pushing       Yes       Pushing       Yes       Pushing         Standing       Yes       Pushing       Yes       Pushing       Yes       Pushing       Yes         Bending/Stooping       Yes </td <td></td> <td></td> <td></td> <td></td> <td></td>					
systems that preclude exposure to:       a. Temperature extremes       Yes       No       c. Gas/fumes       Yes       No         3a. Please review the Guidance for Physicians included on pages 2 and 3 of this form. Based on the parameters provided, please indicate whether this person is capable of working within any of the following Strength Levels:       Sedentary       Yes       No       Light       Yes       No         3b. Please review the Guidance for Physicians included on pages 2 and 3 of this form. Based on the parameters provided, please indicate whether this person is capable of working within any of the following Strength Levels:       Sedentary       Yes       No       Light       Yes       No         3b. If not, please indicate whether this person has any LIMITATION in the activity listed and how many hours this person can perform each activity. If there and timitations in liting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.       # of Hours       # of Hours         Activity       Limitation       Able to Work       Activity       Limitation       Able to Work       List.         Sitting       Yes       Pushing       Yes       Pushing       Yes       Hors         Standing       Yes       Pushing       Yes       Pushing       Yes       Pushing       Yes         Shoulder       Yes       Squatting       Yes       Duration       Frequency			nedical report:		
systems that preclude exposure to:       a. Temperature extremes       Yes       No       c. Gas/fumes       Yes       No         3a. Please review the Guidance for Physicians included on pages 2 and 3 of this form. Based on the parameters provided, please indicate whether this person is capable of working within any of the following Strength Levels:       Sedentary       Yes       No       Light       Yes       No         3b. Please review the Guidance for Physicians included on pages 2 and 3 of this form. Based on the parameters provided, please indicate whether this person is capable of working within any of the following Strength Levels:       Sedentary       Yes       No       Light       Yes       No         3b. If not, please indicate whether this person has any LIMITATION in the activity listed and how many hours this person can perform each activity. If there and timitations in liting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.       # of Hours       # of Hours         Activity       Limitation       Able to Work       Activity       Limitation       Able to Work       List.         Sitting       Yes       Pushing       Yes       Pushing       Yes       Hors         Standing       Yes       Pushing       Yes       Pushing       Yes       Pushing       Yes         Shoulder       Yes       Squatting       Yes       Duration       Frequency					
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b. Airborne particles       Yes       No       d. Electromagnetic radiation       Yes       No         3a. Please review the Guidance for Physicians included on pages 2 and 3 of this form. Based on the parameters provided, please indicate whether this person is capable of working within any of the following Strength Levels:       Sedentary       Yes       No       Light       Yes       No         3a. Please review the Guidance for Physicians included on pages 2 and 3 of this form. Based on the parameters provided, please indicate whether this person is capable of working within any of the following Strength Levels:       Sedentary       Yes       No       Light       Yes       No         3b. If not, please indicate whether this person has any LiMITATION in the activity listed and how many hours this person.       # of Hours       # of Hours <td></td> <td></td> <td></td> <td>16</td> <td></td>				16	
3a. Please review the Guidance for Physicians included on pages 2 and 3 of this form. Based on the parameters provided, please indicate whether this person is capable of working within any of the following Strength Levels:       Sedentary       Yes       No       Light       Yes       No         3b. If not, please indicate whether this person has any. LURTHATION 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.       # of Hours         Activity       Limitation       Able to Work       Activity       Limitation       # of Hours         Activity       Limitation       Able to Work       Activity       Limitation       Able to Work       Lis.         Sitting       Yes       Yes       Wasting       Yes       Hours       # of Hours         Sitting       Yes       Pushing       Yes       Hours       Hours       Hours       Hour	-				
is capable of working within any of the following Strength Levels:   Sedentary Yes No Light Yes No   Medium Yes No Heavy Yes No No   3b. If not, 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 initiations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person. # of Hours   Activity Limitation # of Hours Activity Limitation   Activity Limitation # of Hours   Standing Yes Pulsing   Yes Pushing Yes   Standing Yes Pushing   Yes Pulling Yes   Shoulder Yes Climbing   Shoulder Yes Climbing   Yes Duration Frequency   Operating a Motor Vehicle Yes   offrom work Yes   Operating a Motor Vehicle Yes   offr	b. Airborne particles	Yes No	d. Elec	ctromagnetic radiation	Yes No
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Medium       Yes       No       Yes       No       Very Heavy       Yes       No         3b. If not, please indicate whether this person has any       LIMITATION in the activity listed and how many hours this person can perform each activity. If there and initiations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.       # of Hours         Activity       Limitation       Able to Work       Activity       Limitation       Able to Work       Lbs.         Stiting       Yes       Yes       Repetitive Movements:       Yes       Yes       Hours         Walking       Yes       Pushing       Yes       Yes       Hours         Reaching       Yes       Pushing       Yes       Hours         Shoulder       Yes       Pushing       Yes       Hours         Shoulder       Yes       Lifting       Yes       Hours         Shoulder       Yes       Lifting       Yes       Hours         Shoulder       Yes       Duration       Frequency       Heavy         Vers       Deraking above       Yes       Duration       Frequency       Heavy         Shoulder       Yes       Duration       Frequency       Heavy       Heavy       Heavy       Heavy					
3b. If not, 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.       # of Hours         Activity       Limitation       # of Hours       # of Hours         Activity       Limitation       Able to Work       Activity       Limitation         Sitting       Yes       Presson can perform each activity. If there are indicate whether this person can perform each activity. If there are indicate whether this person can perform each activity. If there are indicate whether this person can perform each activity. If there are indicate whether this person can perform each activity. If there are indicate whether this person can perform each activity. If there are indicate whether this person can perform each activity. If there are indicate and how many hours this person can perform each activity. If there are indicate and how many hours this person can perform each activity. If there are indicate and how many hours this person.         Sitting       Yes       Presson taking       # of Hours         Sitting       Yes       Pulling       Yes       Pulling         Shoulder       Yes       Pulling       Yes       Pulling         Press       Climbing       Yes       Pulling       Yes         Breaking above       Yes       Duration       Frequency       Presson taking MEDICATIONS that impact the ability to work? Please		Medium Yes	s No Heavy	Yes No Ve	
limitations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.       # of Hours         Activity       Limitation       Able to Work       Activity       Limitation         Activity       Limitation       Able to Work       Activity       Limitation         Sitting       Pres       Repetitive Movements:       Pres         Valking       Pres       Pushing       Pres         Reaching above       Pres       Pulling       Pres         Shoulder       Pres       Pulling       Pres         Shoulder       Pres       Lifting       Pres         Shoulder       Pres       Climbing       Pres         Bending/Stooping       Pres       Duration       Frequency         Operating a Motor Vehicle       Pres       Duration       Frequency         at work       Pres       Duration       Frequency         5. If there are 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, please explain in a narrative report.         6. Physician's Name ( <i>Type or print</i> )       7. Telephone Number (Include Area Code)         8. Signature       9. Date       9. Date       100000000000000000000000000000	3b. If not place indicate whether this person ha				
Activity       Limitation       Able to Work       Activity       Limitation       Able to Work       Lbs.         Sitting       Yes       Repetitive Movements:       Yes       Imitation       Able to Work       Lbs.         Sitting       Yes       Wrists       Yes       Imitation       Able to Work       Lbs.         Sitting       Yes       Wrists       Yes       Imitation       Able to Work       Lbs.         Reaching       Yes       Imitation       Yes       Imitation       Able to Work       Lbs.         Reaching above       Yes       Imitation       Yes       Imitation       Yes       Imitation         Shoulder       Yes       Pushing       Yes       Imitation       Yes       Imitation         Shoulder       Yes       Pushing       Yes       Imitation       Yes       Imitation         Shoulder       Yes       Iffing       Yes       Imitation       Yes       Imitation         Shoulder       Yes       Iffing       Yes       Imitation       Yes       Imitation         Operating Motor Vehicle       Yes       Duration       Frequency       Yes       Imitation         4. Is the person taking MEDICATIONS that impact the ability					
Activity Limitation Able to Work Activity Limitation Able to Work Lbs.   Sitting Yes Repetitive Movements: Yes Imitation Able to Work Lbs.   Walking Yes Wrists Yes Imitation Able to Work Lbs.   Standing Yes Wrists Yes Imitation Able to Work Lbs.   Reaching Yes Pushing Yes Imitation Yes Imitation   Shoulder Yes Putling Yes Imitation Yes Imitation   Shoulder Yes Putling Yes Imitation Yes Imitation   Shoulder Yes Putling Yes Imitation Imitation   Shoulder Yes Imitation Yes Imitation Imitation   Shoulder Yes Pushing Yes Imitation Yes Imitation   Shoulder Yes Imitation Yes Imitation Imitation   Shoulder Yes Imitation Yes Imitation Imitation   Shoulder Yes Imitation Pushing Yes Imitation   Shoulder Yes Imitation Imitation Yes Imitation   Operating a Motor Vehicle Yes Imitation Imitation Frequency   state person taking MEDICATIONS that impact the ability to work? Please explain. Imitation of a vosition for this person, please explain in a narrative report.   S. If there are OTHER med					
Walking       Yes       Wrists       Yes         Standing       Yes       Elbow       Yes         Reaching above       Pushing       Yes       Image: Standing       Yes         Shoulder       Yes       Pulling       Yes       Image: Standing       Yes         Shoulder       Yes       Pulling       Yes       Image: Standing       Yes       Image: Standing       Yes         Shoulder       Yes       Squatting       Yes       Image: Standing       Yes       Image: Standing       Yes         Bending/Stooping       Yes       Squatting       Yes       Image: Standing       Yes       Image: Standing       Yes         Operating Motor Vehicle at work       Yes       Image: Standing       Image:	Activity Limitation		<u>Activity</u>	Limitation	
Walking       Yes       Wrists       Yes         Standing       Yes       Elbow       Yes         Reaching above       Pushing       Yes       Image: Standing       Yes         Shoulder       Yes       Pulling       Yes       Image: Standing       Yes         Shoulder       Yes       Pulling       Yes       Image: Standing       Yes       Image: Standing       Yes         Shoulder       Yes       Squatting       Yes       Image: Standing       Yes       Image: Standing       Yes         Bending/Stooping       Yes       Squatting       Yes       Image: Standing       Yes       Image: Standing       Yes         Operating Motor Vehicle at work       Yes       Image: Standing       Image:	Sitting Ves		Repetitive Moveme	nts <sup>.</sup>	
Standing       Yes       Elbow       Yes         Reaching       Yes       Pushing       Yes         Reaching above       Pulling       Yes       Pulling         Shoulder       Yes       Pulling       Yes         Shoulder       Yes       Lifting       Yes         Bending/Stooping       Yes       Squatting       Yes         Operating Motor Vehicle at work       Yes       Climbing       Yes         Operating a Motor Vehicle to/from work       Yes       Duration       Frequency         4. Is the person taking MEDICATIONS that impact the ability to work? Please explain.       Frequency       Image: Standing in a narrative report.         6. Physician's Name ( <i>Type or print</i> )       7. Telephone Number (Include Area Code)       Image: Standing in a narrative report.         8. Signature       9. Date       9. Date       Image: Standing in a narrative report.			•		
Reaching       Yes       Pushing       Yes         Reaching above       Yes       Pulling       Yes         Shoulder       Yes       Pulling       Yes         Shoulder       Yes       Pulling       Yes         Shoulder       Yes       Stating       Yes         Bending/Stooping       Yes       Squatting       Yes         Operating Motor Vehicle       Yes       Climbing       Yes         at work       Yes       Duration       Frequency         4. Is the person taking MEDICATIONS that impact the ability to work? Please explain.       Frequency       Frequency         5. If there are 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, please explain in a narrative report.         6. Physician's Name ( <i>Type or print</i> )       7. Telephone Number (Include Area Code)         8. Signature       9. Date					
Reaching above       Pulling       Yes         Shoulder       Yes       Pulling         Twisting       Yes       Squatting         Bending/Stooping       Yes       Squatting         Operating Motor Vehicle at work       Yes       Climbing         Operating Motor Vehicle to/from work       Yes       Duration         Frequency       Frequency       Frequency         4. Is the person taking MEDICATIONS that impact the ability to work? Please explain.       Frequency         5. If there are 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, please explain in a narrative report.         6. Physician's Name ( <i>Type or print</i> )       7. Telephone Number (Include Area Code)         8. Signature       9. Date					
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OWCP-5b (Rev. 08-14)					OWCP-5b (Rev. 08-14)

### Physical Demand Definitions for the OWCP

OWCP has adopted the following Strength Level definitions to indicate the absence or presence and frequency of the physical demand components requested on the OWCP-5b and OWCP-5c.

#### 1. STRENGTH LEVEL

#### Sedentary Work

Sedentary Work involves exerting up to 10 pounds of force occasionally or a negligible amount of force frequently to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs may be defined as Sedentary when walking and standing are required only occasionally and all other Sedentary criteria are met.

#### Light Work

Light Work involves exerting up to 20 pounds of force occasionally or up to 10 pounds of force frequently, or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may be only a negligible amount, a job/occupation is rated Light Work when it requires: (1) walking or standing to a significant degree; (2) sitting most of the time while pushing or pulling arm or leg controls; or (3) working at a production rate pace while constantly pushing or pulling materials even though the weight of the materials is negligible. (The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.)

#### **Medium Work**

Medium Work involves exerting 20 to 50 pounds of force occasionally or 10 to 25 pounds of force frequently or an amount greater than negligible and up to 10 pounds constantly to move objects. Physical demand requirements are in excess of these for Light Work.

#### Heavy Work

Heavy Work involves exerting 50 to 100 pounds of force occasionally, or 25 to 50 pounds of force frequently, or 10 to 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Medium Work.

#### Very Heavy Work

Very Heavy work involves exerting in excess of 100 pounds of force occasionally, or in excess of 50 pounds of force frequently or in excess of 20 pounds of force constantly to move objects, Physical demand requirements are in excess of those for Heavy Work.

Rating	Occasionally	Frequently	Constantly		
Sedentary	* - 10	*	N/A		
Light	* - 20	* - 10	*		
Medium	20 - 50	10 - 25	* - 10		
Heavy	50 - 100	25 - 50	10 - 20		
Very Heavy	100 +	50 +	20 +		
* = negligible weight; N/A = Not Applicable					

#### LIMITS OF WEIGHTS LIFTED/CARRIED/PUSHED/PULLED

The range excludes the lower number and includes the higher number, i.e., the range 10 - 25 excludes 10 (begins at 10 +) and includes 25.

#### PRESENCE AND/OR FREQUENCY OF OTHER PHYSICAL DEMANDS

The following codes and definitions indicate the absence or presence and frequency of other Physical Demand components requested on the OWCP-5b and OWCP-5c.

<u>Code</u>	<b>Frequency</b>	Definition	<u>Max # hrs./8-hr. day</u>
Ν	Not Present	Activity/condition does not exist.	0
0	Occasionally	Activity/condition exists up to 1/3 of the time.	2 hrs. 40 min.
F	Frequently	Activity/condition exists from 1/3 to 2/3 of the time.	5 hrs. 20 min.
С	Constantly	Activity/condition exists 2/3 or more of the time.	8

#### 2. REACHING

Forward flexion and/or abduction of the hand(s) and arm(s); generally, within a  $0^{\circ}$  -  $90^{\circ}$  range of motion from the shoulder; or extension within a  $0^{\circ}$  -  $50^{\circ}$  range of motion from the shoulder.

#### **3. REACHING ABOVE THE SHOULDER**

Forward flexion and/or abduction of the hand(s) and arm(s); generally at greater than 90° from the shoulder.

#### 4. TWISTING

Turning, twisting, contorting, or flexing the torso in any direction towards the right or left.

#### 5. BENDING/STOOPING

Bending body downward and forward by bending spine at the waist requiring full use of the lower extremities and back muscles.

#### 6. OPERATING A MOTOR VEHICLE AT WORK

Driving any vehicle during the performance of one's duties.

#### 7. REPETITIVE MOVEMENTS OF ELBOWS (HANDLING)

Seizing, holding, grasping, turning, or otherwise working with hand or hands using the whole arm.

#### 8. REPETITIVE MOVEMENTS OF WRISTS (FINGERING)

Picking, pinching, or otherwise working primarily with fingers and wrists rather than the whole arm as in handling.

#### 9. SQUATTING (CROUCHING)

Bending body downward and forward by bending legs and spine.

#### **10. KNEELING**

Bending legs at knees to come to rest on knee or knees.

#### 11. CLIMBING

Ascending or descending ladders, stair, scaffolding, ramps, poles, and the like, using feet and legs or hands and arms. Body agility is emphasized.

#### **Privacy Act Statement**

The Privacy Act of 1974 as amended (5 U. S.C. 552a) and the Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.), authorizes collection of this information. The purpose of this form is to obtain the claimant's specific work tolerance limitation where the accepted condition is cardiovascular/pulmonary in nature. Completion of this form is voluntary (5 U.S.C. 8101, et seq), however, failure to provide the information may result in the delay of processing of the claim or payment or benefits, or may result in an unfavorable decision or reduced levels of benefits. 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.

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#### Notice

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or the claims examiner to ask about this assistance.