



UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD
OFFICE NAME
ADDRESS
CITY, STATE, ZIP
WWW.RRB.GOV

Form Approved
OMB No. 3220-0038

Proposed

MEDICAL ASSESSMENT OF RESIDUAL FUNCTIONAL CAPACITY

NAME	RRB CLAIM NUMBER	SOCIAL SECURITY NUMBER
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INSTRUCTIONS

Complete this form and submit to us along with your narrative report and office records, as requested on the enclosed cover letter. Describe below any restrictions in the claimant's ability to perform basic work-related functions within a regular work setting on a day-to-day basis. **Relate any assessed reduction to capacity to particular medical findings.** Do not consider non-medical factors such as age, sex, education, or work experience.

Note: You may include this medical assessment in your narrative report, however, we prefer you use this Form G-250A.

When using this form, use the space to the left of a function or condition to enter "NA" if you find that it is NOT AFFECTED by the claimant's impairment(s). If you are unable to assess the claimant's ability to perform an activity or tolerate a condition shown, use the space to show "UNK" indicating UNKNOWN. Otherwise, complete as appropriate, being sure to explain limitations and relate them to specific findings in the space provided.

Please read page 4 for the authorization for this report and other important notices.

A. **Exertional Restrictions** - For all claimants with physical impairments.

1. _____ In an 8-hour workday claimant can STAND and/or WALK, with normal breaks, for:

less than 2 hours total at least 2 hours total 6 hours or more

MEDICAL FINDINGS TO SUPPORT RESTRICTION:

2. _____ In an 8-hour workday claimant can SIT, with normal breaks, for:

less than 6 hours total 6 hours or more

MEDICAL FINDINGS TO SUPPORT RESTRICTION:

A. **Exertional Restrictions**, Continued

3. _____ Claimant can LIFT:	Unlimited	Frequently ¹	Occasionally ²	Never
Less than 10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 pounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100 pounds or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL FINDINGS TO SUPPORT RESTRICTIONS:

4. Claimant is able to:	Unlimited	Frequently ¹	Occasionally ²	Never
_____ Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Crouch/Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Reach above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL FINDINGS TO SUPPORT RESTRICTIONS:

5. Claimant can use BOTH HANDS for repetitive:	YES	NO (Limitation MUST be explained)
_____ Simple Grasping	<input type="checkbox"/>	<input type="checkbox"/>
_____ Fine Manipulation	<input type="checkbox"/>	<input type="checkbox"/>
_____ Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>
6. Claimant can use BOTH FEET for repetitive:		
_____ Foot Controls	<input type="checkbox"/>	<input type="checkbox"/>
7. Claimant can, without restriction:		
_____ See	<input type="checkbox"/>	<input type="checkbox"/>
_____ Hear	<input type="checkbox"/>	<input type="checkbox"/>
_____ Speak	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL FINDINGS TO SUPPORT RESTRICTIONS:

¹ **FREQUENTLY** means occurring one-third to two-thirds of an 8-hour workday; cumulative, not continuous.

² **OCCASIONALLY** means occurring from very little up to one-third of an 8-hour workday; cumulative, not continuous.

B. Environmental Restrictions - For all claimants, as applicable.

Claimant is restricted in activities involving:	No	Mildly ³	Moderately ⁴	Totally
_____ Unprotected Heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Driving/Operating Machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Being around moving Machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Uneven Terrain/Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Exposure to Dust, Fumes, Etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Exposure to Noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Exposure to Vibration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Exposure to Temperature Extremes/Humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL FINDINGS TO SUPPORT RESTRICTIONS:

C. Mental Restrictions - For all claimants with mental impairments.

Claimant is limited in ability to:	No	Mildly ³	Moderately ⁴	Totally
_____ Reason/Use Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Maintain Appropriate Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Maintain Personal Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Perform Normal Daily Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Make Social Adjustments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Relate to Other People	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Make Occupational Adjustments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Maintain Normal Work Pace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Maintain Normal Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____ Remember/Understand/Carry Out Instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL FINDINGS TO SUPPORT RESTRICTIONS:

In your opinion, is the claimant able to handle benefit payments in his/her own best interest

Yes

No

³ **MILDLY** means tolerance/ability to function is limited but satisfactory.

⁴ **MODERATELY** means tolerance/ability to function is seriously limited, but not precluded.

Certification

With the understanding that section 13 of the Railroad Retirement Act (45 U.S.C. 2311) provides that anyone who makes false or fraudulent statements or claims for the purpose of causing an award or payment under the Railroad Retirement Act is subject to a fine of up to \$10,000, or imprisonment of up to one year, or both, I certify that the information I have furnished is correct to the best of my knowledge.

Signature

Date

Printed Name and Title

National Provider Identifier

Address and Daytime Telephone Number

Area Code

Telephone Number

Please return this form along with copies of your office records to:

RAILROAD RETIREMENT BOARD

OFFICE NAME

ADDRESS

CITY, STATE, ZIP

IMPORTANT NOTICES**PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES**

The information requested on this form is authorized by Section 7(b)(6) of the Railroad Retirement Act. While you are not required to respond, your cooperation is needed to provide information necessary to complete processing for the claimant named and to determine the claimant's entitlement to disability benefits under the Railroad Retirement Act.

We estimate this form takes an average of 30 minutes per response to complete, including time for reviewing the instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to ~~Chief of Information Resources Management~~, Railroad Retirement Board, 844 N. Rush Street, Chicago, IL 60611-1275.

Associate Chief Information Officer for Policy and Compliance

COMPUTER MATCHING AND PRIVACY PROTECTION ACT NOTICES

The Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503) requires the Railroad Retirement Board to advise you that information you have provided may be used, without your consent, in automated matching programs. These matching programs are a computer comparison of RRB records with records kept by other Federal, state, or local governmental agencies. Information from the programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.