Form Approved
OMB No.0960-0662

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)

NAME OF INDIVIDUAL **SOCIAL SECURITY NUMBER**

To determine this individual's ability to do **work-related activities on a regular and continuous basis**, please give us your opinion for each activity shown below:

The following terms are defined as:

- **REGULAR AND CONTINUOUS BASIS** means 8 hours a day, for 5 days a week, or an equivalent work schedule.
- **OCCASIONALLY** means very little to one-third of the time.
- **FREQUENTLY** means from one-third to two-thirds of the time.
- **CONTINUOUSLY** means more than two-thirds of the time.

Age and body habitus of the individual should not be considered in the assessment of limitations. It is important that you relate particular medical or clinical findings to any assessed limitations in capacity: The usefulness of your assessment depends on the extent to which you do this.

I. LIFTING/CARRYING

Check the boxes representing the amount the individual can lift and how often it can be lifted.

Lift	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:				
B. 11 to 20 lbs:				
C. 21 to 50 lbs:				
D. 51 to 100 lbs:				

Check the boxes representing the amount the individual can carry and how often it can be carried.

Carry	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:				
B. 11 to 20 lbs:				
C. 21 to 50 lbs:				
D. 51 to 100 lbs:				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

II. SITTING/STANDING/WALKING

Please check how many hours the individual can (if less than one hour, how many minutes):

At One Time without Interruption

	Minutes	Hours							
A. Sit	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
B. Stand	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
C. Walk	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Total in an 8 hour work day

	Minutes	Hours							
A. Sit	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
B. Stand	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
C. Walk	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

If the total time for sitting, standing and walking does not equal or exceed 8 hours, what activity is the individual performing for the rest of the 8 hours?

Does the individual require the use of a cane to ambulate? ☐ Yes ☐ No

If the answer is "yes" please answer the following:

- How far can the individual ambulate without the use of a cane? _____
- Is the use of a cane medically necessary? ☐ Yes ☐ No
- With a cane, can the individual use his/her free hand to carry small objects? ☐ Yes ☐ No

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

III. USE OF HANDS

Indicate how often the individual can perform the following activities:

ACTIVITY	Right Hand					Left Hand			
	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)		Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
REACHING (Overhead)									
REACHING (All Other)									
HANDLING									
FINGERING									
FEELING									
PUSH/PULL									

Which is the individual's dominant hand? ☐ Right Hand ☐ Left Hand

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

IV. USE OF FEET

Indicate how often the individual can perform the following activities:

ACTIVITY	Right Foot					Left Foot			
	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)		Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Operation of Foot Controls									

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

V. POSTURAL ACTIVITIES

How often can the individual perform the following activities?

ACTIVITY	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Climb stairs and ramps				
Climb ladders or scaffolds				
Balance				
Stoop				
Kneel				
Crouch				
Crawl				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

VI. DO ANY OF THE IMPAIRMENTS AFFECT THE CLAIMANT'S HEARING OR VISION?

☐ No ☐ Yes ☐ Not Evaluated

If "yes" please complete the following questions (where appropriate)

1. If a **hearing impairment** is present,

   a. Does the individual retain the ability to hear and understand simple oral instructions and to communicate simple information? ☐ Yes ☐ No
   b. Can the individual use a telephone to communicate? ☐ Yes ☐ No

2. If a **visual impairment** is present,

   a. Is the individual able to avoid ordinary hazards in the workplace, such as boxes on the floor, doors ajar, or approaching people or vehicles? ☐ Yes ☐ No

   b. Is the individual able to read very small print? ☐ Yes ☐ No

   c. Is the individual able to read ordinary newspaper or book print? ☐ Yes ☐ No

   d. Is the individual able to view a computer screen? ☐ Yes ☐ No

   e. Is the individual able to determine differences in shape and color of small objects such as screws, nuts or bolts? ☐ Yes ☐ No

      Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

VII. ENVIRONMENTAL LIMITATIONS

How often can the individual tolerate exposure to the following conditions?

Condition	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Unprotected Heights				
Moving Mechanical Parts				
Operating a motor vehicle				
Humidity and wetness				
Dust, odors, fumes and pulmonary irritants				
Extreme cold				
Extreme heat				
Vibrations				
Others: (Identify)				

Condition	Quiet (Library)	Moderate (Office)	Loud (Heavy Traffic)	Very Loud (Jackhammer)
Noise				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain, etc.) which support your assessment or any limitations and why the findings support the assessment.

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VIII. PLEASE PLACE A CHECK IN APPROPRIATE BOXES BASED SOLELY ON THE CLAIMANT'S PHYSICAL IMPAIRMENTS

ACTIVITY	YES	No
Can the individual perform activities like shopping?		
Can the individual travel without a companion for assistance?		
Can the individual ambulate without using a wheelchair, walker, or 2 canes or 2 crutches?		
Can the individual walk a block at a reasonable pace on rough or uneven surfaces?		
Can the individual use standard public transportation?		
Can the individual climb a few steps at a reasonable pace with the use of a single hand rail?		
Can the individual prepare a simple meal & feed himself/herself?		
Can the individual care for their personal hygiene?		
Can the individual sort, handle, or use paper/files?		

Please identify the medical findings that support this assessment and why the finding support the assessment (unless a narrative report is attached).

IX. STATE ANY OTHER WORK-RELATED ACTIVITIES, WHICH ARE AFFECTED BY ANY IMPAIRMENTS, AND INDICATE HOW THE ACTIVITIES ARE AFFECTED. WHAT ARE THE MEDICAL FINDINGS THAT SUPPORT THIS ASSESSMENT?

X. THE LIMITATIONS ABOVE ARE ASSUMED TO BE YOUR OPINION REGARDING CURRENT LIMITATIONS ONLY.

HOWEVER, IF YOU HAVE SUFFICIENT INFORMATION TO FORM AN OPINION WITHIN A REASONABLE DEGREE OF MEDICAL PROBABILITY AS TO PAST LIMITATIONS, ON WHAT DATE WERE THE LIMITATIONS YOU FOUND ABOVE FIRST PRESENT? _____

XI. HAVE THE LIMITATIONS YOU FOUND ABOVE LASTED OR WILL THEY LAST FOR 12 CONSECUTIVE MONTHS? ☐ **Yes** ☐ **No**

_____ _____

SIGNATURE DATE

_____

Print Name, Title and Medical Specialty (Legibly Please)

Privacy Act Statement

Collection and Use of Personal Information

Sections 205(a), 223(d), 1614(a) and 1631(d) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on the named claimant's eligibility for benefits

We will use the information to make a determination of eligibility for benefits. We may also share your information for the following purposes, called routine uses:

1. To Federal, State, or local agencies for administering cash or non-cash income maintenance or health maintenance programs; and;

2. To student volunteers and other workers, who technically do not have the status of Federal employees, when they are performing work for the Social Security Administration (SSA) as authorized by law, and they need access to personally identifiable information in SSA records in order to perform their assigned agency functions.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notice (SORN) 60-0089, entitled Claims Folders Systems. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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