



Injured Worker's Name ( <i>First, middle, last</i> ) <input type="text"/>	OWCP No. <input type="text"/>	OMB No: 1240-0046 Expires: XX-XX-XXXX
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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 in a narrative report.

3. Is the worker competent to perform his/her usual job?  Yes  No If no, in a narrative report 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 ( <i>Type or print</i> ) <input type="text"/>	7. Telephone (Include Area Code) <input type="text"/>
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8. Signature	9. Date <input type="text"/>
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## **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 psychiatric or psychological 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.

## **Public Burden Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to this collection of information unless it displays a currently valid OMB control number. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is required to obtain or retain a benefit under 5 U.S.C. 8101, et seq. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210, and reference the OMB Control Number 1240-0046. Note: Please do not return the requested information to the address shown just above. Rather, send it to the address shown on the letterhead.

## **Notice**

### **Requests for Accommodations or Auxiliary Aids and Services**

If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance, accommodation(s) and/or modification(s) 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 accommodate your disability. Please contact our office or your OWCP claims examiner to ask about this assistance.