

Work Capacity Evaluation  
Cardiovascular/Pulmonary Conditions

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



Injured Worker's Name ( <i>First, middle, last</i> ) <input style="width:100%;" type="text"/>	OWCP No. <input style="width:100%;" 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:

1a. Is this employee capable of performing his/her usual job without restriction?  Yes  No If no, is **prevention** (of possible future injury) the **only reason** for work limitations?  Yes  No **If prevention is not the only reason**, please explain your medical reason to support your 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 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  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:

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 <input type="checkbox"/> Yes <input type="checkbox"/> No | c. Gas/fumes <input type="checkbox"/> Yes <input type="checkbox"/> No                 |
| b. Airborne particles <input type="checkbox"/> Yes <input type="checkbox"/> No   | d. Electromagnetic radiation <input type="checkbox"/> Yes <input type="checkbox"/> 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:

- |  |   |   |   |  |
|--|---|---|---|--|
| <b>Medium</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Sedentary</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Heavy</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Light</b> <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Very Heavy</b> <input type="checkbox"/> Yes <input type="checkbox"/> 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 limitations in lifting, pulling and/or pushing, please provide the maximum number of pounds that can be handled by this person.

Activity	Limitation	# of Hours Able to Work	Activity	Limitation	# of Hours Able to Work	Lbs.
Sitting	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	Repetitive Movements:			
Walking	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	Wrists	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	
Standing	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	Elbow	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	
Reaching	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	Pushing	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>
Reaching above			Pulling	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>
Shoulder	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	Lifting	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>
Twisting	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	Squatting	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>
Bending/Stooping	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	Kneeling	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>
Operating Motor Vehicle at work	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	Climbing	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>	<input style="width:40px;" type="text"/>
Duration <input style="width:80px;" type="text"/>		Frequency <input style="width:80px;" type="text"/>	Breaks: Duration <input style="width:80px;" type="text"/>		Frequency <input style="width:80px;" type="text"/>	
Operating a Motor Vehicle to/from work	<input type="checkbox"/> Yes	<input style="width:40px;" type="text"/>				

4. Is the person taking **MEDICATIONS** that impact the ability to work? Please explain.

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> ) <input style="width:100%;" type="text"/>	7. Telephone Number (Include Area Code) <input style="width:100%;" type="text"/>
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8. Signature <input style="width:100%;" type="text"/>	9. Date <input style="width:100%;" type="text"/>
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## 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.

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

<b>Rating</b>	<b>Occasionally</b>	<b>Frequently</b>	<b>Constantly</b>
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			

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.

## Physical Demand Definitions for the OWCP (continued)

### 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.

<b>Code</b>	<b>Frequency</b>	<b>Definition</b>	<b>Max # hrs./8-hr. day</b>
N	Not Present	Activity/condition does not exist.	0
O	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.
C	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° - 90° range of motion from the shoulder; or extension within a 0° - 50° 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.

## **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.