CAPACITY FOR PART TIME V. FULL TIME WORK

Name:									
Claim #:									
Date of Injury:									
Please Print Name of Medical Evaluator:									
Medical Specialty:									
What is the first date claimant's impairment(s) became "severe" meaning that they caused interference in ADL's or ability to work?						Date:			
When did you begin treating the claimant?						Date:			
How frequently do you see your claimant?						Date:			
Within a reasonable degree of medical probability and considering the following: 1. The ability to perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances. 2. The ability to complete a normal workday and workweek without interruptions from symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.									
Can the claimant reasonably be expected to engage in sustained competitive work 8 hours a day 5 days a week taking into account the 2 psychological functions supra?						YES☐		NO☐	
If no; how many <u>hours</u> can the claimant reasonably expect to work each day if vocationally and medically compatible work is identified?	<1	1	2	3	4	5	6	7	8
Taking into account your opinion above how many days a week do you believe the claimant can be expected work?					1	2	3	4	5
If claimant experiences "good days" and "bad days" is it medically probable to expect that the estimates provided above may vary and have an impact on reliability and dependability?						YES☐		NO☐	

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the report accurately describes the information provided to me and except as noted herein, that I believe it to be true. I also declare under the perjury that this physician has no violated section 139.3 of the Labor Code.

My opinions are expressed to a degree of medical probability, unless otherwise stated.

Signature of Physician_____ Date _____