Bureau of Workers' Compensation

Disability Evaluator Panel (DEP) Physician's Report of Work Ability Physical Conditions

Instructions

- Complete the items below on your clinical evaluation and other testing results of the injured worker per an eight-hour workday.
- Check appropriate boxes as you complete this form.

Injured worked name	Claim number	Date of injury
DEP physician		Date of exam

Work/Non-work capabilities

Please indicate which of the following activities the injured worker can perform.

The injured worker is able to perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker is able to perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker's dominant hand and is: ☐ Left hand ☐ Right hand

The injured worker is able to perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both

If the injured worker is taking prescribed medications for the allowed conditions in this claim, can the injured worker safely:

Operate heavy machinery ☐ Yes ☐ No Drive ☐ Yes ☐ No

Perform other critical job tasks (defined by job description and/or injured worker) ☐ Yes ☐ No

Please explain the other critical tasks_____

_____

Classes of restriction	Never	Occasionally	Frequently	Continuously	No restriction
Description of Restriction Severity	Never	Four to six repetitions per hour	Six to 12 repetitions per hour	Greater than 12 repetitions per hour	No restriction is noted
Percentage of workday (8 hours)	Never (N) 0%	Occasional (O) 1%-33%	Frequent (F) 34%-66%	Continuous (C) 67%-100%	No restriction (NR)
Activity					
Bend	◯ N	◯ O	◯ F	◯ C	◯ NR
Squat/Kneel	◯ N	◯ O	◯ F	◯ C	◯ NR
Twist/turn	◯ N	◯ O	◯ F	◯ C	◯ NR
Climb	◯ N	◯ O	◯ F	◯ C	◯ NR
Reach above shoulder	◯ N	◯ O	◯ F	◯ C	◯ NR
Type/keyboard	◯ N	◯ O	◯ F	◯ C	◯ NR
Work with cold substances	◯ N	◯ O	◯ F	◯ C	◯ NR
Work with hot substances	◯ N	◯ O	◯ F	◯ C	◯ NR
Lifting/carrying					
0 – 10 lbs	◯ N	◯ O	◯ F	◯ C	◯ NR
11 – 20 lbs.	◯ N	◯ O	◯ F	◯ C	◯ NR
21 – 40 lbs	◯ N	◯ O	◯ F	◯ C	◯ NR
41 – 60 lbs	◯ N	◯ O	◯ F	◯ C	◯ NR
61 – 100 lbs	◯ N	◯ O	◯ F	◯ C	◯ NR
Pushing/pulling					
0 - 25 lbs	◯ N	◯ O	◯ F	◯ C	◯ NR
26 - 40 lbs	◯ N	◯ O	◯ F	◯ C	◯ NR
41 - 60 lbs	◯ N	◯ O	◯ F	◯ C	◯ NR
61 - 100 lbs	◯ N	◯ O	◯ F	◯ C	◯ NR
100 + lbs	◯ N	◯ O	◯ F	◯ C	◯ NR

Are the restrictions: ☐ temporary ☐ permanent

If temporary, give an opinion as to the expected duration of the restrictions: from _____ to _____

In an eight-hour workday, how many total hours is the injured worker able to work: per week? _____ per day? _____

In an eight-hour workday, how many total hours is the injured worker able to:

Sit: ____ hours ☐ Continuously ☐ With break Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break

In the space below please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed in the selections above.

I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Physician signature (required) Date: