



EMPLOYEE PHYSICAL ABILITY AND ASSESSMENT (EPAA)

Medical University Hospital Authority
 Medical University of South Carolina
 University Medical Associates

MEDICAL PROVIDER: Please document employee's activity limits at each visit.
 (Position description is available to assist Provider in making this determination.)

Employee Name _____	Birth date ____/____/____	MUSC Employee ID _____
Job Title _____	Injury Date ____/____/____	Visit Date ____/____/____

	Activity	May not perform	May perform up to 20 minutes/ hour	May perform up to 40 minutes/ hour		Activity	May not perform	May perform up to 20 minutes/ hour	May perform up to 40 minutes/ hour
<input type="checkbox"/>	Standing				<input type="checkbox"/>	Squatting			
<input type="checkbox"/>	Sitting				<input type="checkbox"/>	Stooping			
<input type="checkbox"/>	Walking				<input type="checkbox"/>	Crawling			
<input type="checkbox"/>	Climbing				<input type="checkbox"/>	Reach			
<input type="checkbox"/>	Kneeling				<input type="checkbox"/>	Overhead Work			
<input type="checkbox"/>	Bending at Waist				<input type="checkbox"/>	Pushing / Pulling			
<input type="checkbox"/>	Twisting at Waist				<input type="checkbox"/>	Repetitive Motion			
<input type="checkbox"/>	Fingers and Hands	may not use			<input type="checkbox"/>	Lower Extremities	may not use		
<input type="checkbox"/>	Vibration exposure				<input type="checkbox"/>	Work rotating shifts	not allowed	allowed	

<input type="checkbox"/> Lift & carry	should be limited to (circle one): 50 45 40 35 30 25 20 15 10 5 0 pounds
<input type="checkbox"/> Lift overhead	should be limited to (circle one): 50 45 40 35 30 25 20 15 10 5 0 pounds
<input type="checkbox"/> Endurance / Work hours	<input type="checkbox"/> Sedentary duty <input type="checkbox"/> Work hours should be limited to (circle one): 12 11 10 9 8 7 6 5 4 3 2 1 hours per day
<input type="checkbox"/> Work Environments	<input type="checkbox"/> Indoor work limited to _____ <input type="checkbox"/> Confined/Cramped spaces work limited to _____ <input type="checkbox"/> Outdoor extreme temperatures work limited to _____ <input type="checkbox"/> Working at heights limited to _____
<input type="checkbox"/> Additional Instructions	<input type="checkbox"/> Alternate position (sit, stand, walk) _____ <input type="checkbox"/> Driving restrictions: _____ <input type="checkbox"/> Elevate _____ <input type="checkbox"/> Crutches / Splint should be used _____
<input type="checkbox"/> Other	

Diagnosis: _____	Medications: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Will this patient be taking medication(s) that impede ability to safely perform any functions of their job? <input type="checkbox"/> Yes <input type="checkbox"/> No I have reviewed the Physical Requirements for this employee's job.	
Based on my evaluation of this employee, I recommend:	
<input type="checkbox"/> Employee can work with NO RESTRICTIONS, beginning (date) _____	
<input type="checkbox"/> Employee can work WITH RESTRICTIONS [as marked above], beginning (date) _____	
<input type="checkbox"/> Employee CANNOT RETURN TO WORK at this time; will be out of work until (date) _____ Medical reason: _____	
<input type="checkbox"/> Being out of work at this time is at the EMPLOYEE'S CHOICE; Not Medically Necessary.	
<input type="checkbox"/> Follow-up appointment on (date) _____ at _____ AM/PM	
<input type="checkbox"/> Discharged from Care on (date) _____	
Comments: _____	
Medical Provider (print) _____ (signature) _____ Address _____ Phone _____	