Work Capacity Evaluation for Disability Insurance

Patient Information

Name

Date of Birth

Patient ID/Number

Diagnosis

Primary Diagnosis

Secondary Diagnosis(es)

Treatment Plan

Describe current treatment plan

Work Capacity Assessment

Patient is able to (select all that apply):

- [ ] Work full time
- [ ] Work part time
- [ ] Work with restrictions
- [ ] Unable to work

Functional Limitations

List and describe any functional limitations

Expected Duration of Limitations

Weeks

Months

Additional Comments

Comments

Provider Information

Provider Name

Specialty

Phone Number

Date

Signature