

Work Capacity Evaluation  
Cardiovascular/Pulmonary Conditions

U.S. Department of Labor

Employment Standards Administration  
Office of Workers' Compensation Programs

ME-OW



Injured Worker's Name (First, middle, last)

OWCP No.

OMB No: 1215-0103

Expires: 08/31/2005

Please answer the questions below concerning your patient (named above) for whom the Office of Workers' Compensation Programs (OWCP) has accepted the following conditions:

1.a. Is this employee capable of performing his/her usual job?  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 for limitations:

**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 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: \_\_\_\_\_

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	Yes	No	c. Gas/fumes	Yes	No
b. Airborne particles	Yes	No	d. Electromagnetic radiation	Yes	No

3. 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	___ Yes	_____	Pushing	___ Yes	_____	_____
Walking	___ Yes	_____	Pulling	___ Yes	_____	_____
Standing	___ Yes	_____	Lifting	___ Yes	_____	_____
Reaching	___ Yes	_____	Squatting	___ Yes	_____	_____
Bending	___ Yes	_____	Kneeling	___ Yes	_____	_____
Operating a Motor Vehicle	___ Yes	_____	Climbing	___ Yes	_____	_____

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

5. Are there **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? If so, please explain.

6. Physician's Name (Type or print)

7. Telephone

8. Signature

9. Date

The information requested will assist OWCP in determining eligibility to benefits and is required to obtain or retain a benefit.  
(5 USC 8101 et. seq.)

**Public Burden Statement**

We estimate that it will take an average of 15 minutes per response to complete this information collection including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

**DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.**

Form OWCP-5b  
Rev October 2001