RESIDUAL FUNCTION ASSESSMENT

INJURED WORKER: CLAIM NUMBER(S):

Based solely on impairment arising from the allowed condition(s) within my specialty, and with no consideration of the Injured Worker's age, education, and work experience:

( ) This Injured Worker has no work limitations.

( ) This Injured Worker is incapable of work.

( ) This Injured Worker is capable of work with the limitation(s) / modification(s) noted below:

Physician Signature: _____

Physician Name (Print): _____

Date: _____

SPECRPT