MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)

NAME OF INDIVIDUAL	SOCIAL SECURITY NUMBER

THIS STATEMENT ADDRESSES LIMITATIONS FROM _____ TO THE PRESENT.

SECTION 1: SITTING/STANDING/WALKING

At One Time Without Interruption

	Minutes	Hours							
A. **Sit**	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
B. **Stand**	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
C. **Walk**	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Total Time In An 8-Hour Workday

	Minutes	Hours							
A. **Sit**	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
B. **Stand**	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
C. **Walk**	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Please identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment in Section 1:

SECTION 2: USE OF LOWER EXTREMITIES

Is any of the following medically necessary?

☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair

Does the patient need to elevate a leg/legs to a position at or above waist level?

☐ No

☐ Yes—For at least :

Hours ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐7 ☐ 8

	YES	NO
Can the individual walk a block at a reasonable pace on rough or uneven surfaces?		
Can the individual climb a few steps at a reasonable pace with the use of a single hand rail?		

Would the patient need to lie down for periods of time periodically from when the patient gets out of bed in the morning through the next 8 hours?

☐ No

☐ Yes—For at least:

Hours ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐7 ☐ 8

Please identify the particular medical or clinical findings (i.e., physical exam findings, x-ray/MRI/CT scan findings, clinical and laboratory testing/diagnostic techniques, etc.) which support your assessment in Section 2:

SECTION 3: USE OF UPPER EXTREMITIES

Right Upper Extremity

Activity	Never	Occasionally (up to 1/3 of an 8 hr day)	Frequently (1/3 to 2/3 of an 8 hr day)	Continually (over 2/3 of an 8 hr day)
REACHING (Overhead)				
REACHING (All Other)				
HANDLING				
FINGERING				
FEELING				

Left Upper Extremity

Activity	Never	Occasionally (up to 1/3 of an 8 hr day)	Frequently (1/3 to 2/3 of an 8 hr day)	Continually (over 2/3 of an 8 hr day)
REACHING (Overhead)				
REACHING (All Other)				
HANDLING				
FINGERING				
FEELING				

Lifting/Carrying

Max Lift/Carry	Never	Occasionally (up to 1/3 of an 8 hr day)	Frequently (1/3 to 2/3 of an 8 hr day)	Continuously (over 2/3 of an 8 hr day)
Up to 10 lbs.				
11 to 20 lbs.				
21 to 50 lbs.				
51 to 100 lbs.				

Please identify the particular medical or clinical findings (i.e., physical exam findings, x-ray/MRI/CT scan findings, clinical and laboratory testing/diagnostic techniques, etc.) which support your assessment in Section 3:

SECTION 4: POSTURAL LIMITATIONS

Activity	Never	Occasionally (up to 1/3 of an 8 hr day)	Frequently (1/3 to 2/3 of an 8 hr day)	Continually (over 2/3 of an 8 hr day)
Climb stairs and ramps				
Balance				
Stoop				
Kneel				
Crouch				

Please identify the particular medical or clinical findings (i.e., physical exam findings, x-ray/MRI/CT scan findings, clinical and laboratory testing/diagnostic techniques, etc.) which support your assessment in Section 4:

_____ _____

Signature Date

_____ _____

Printed Name (Legibly please) Medical Specialty