



North Dakota Workforce  
Safety & Insurance

**CAPABILITY ASSESSMENT**  
CLAIMS DIVISION  
SFN 58550 (10/2024)

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Bismarck ND 58506-5585  
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TTY (hearing impaired) 800-366-6888  
Fraud and Safety Hotline 800-243-3331  
www.workforcesafety.com

Please type or print using black or blue ink. Return the completed and signed form to WSI immediately.

<b>SECTION 1 – Claim information - completion of this section is required</b>					
Claim number	Injured employee's (First name)	(Last name)	Social Security number*	Date of birth	
Employee's mailing address (Street address, PO Box number)					
City	State	ZIP Code	Employee's telephone number		
Date of injury	Employer's name		Employer's telephone number		
<b>SECTION 2 – Medical assessment</b>					
Diagnosis code/ICD-10 code	Date of visit	Body part(s) injured	Purpose of visit <input type="checkbox"/> Initial evaluation <input type="checkbox"/> Re-check <input type="checkbox"/> Discharge		
Before this injury, did the employee have any problems, injuries, or treatment to the injured body part? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Injured employee is released to work with <input type="checkbox"/> No restrictions <input type="checkbox"/> The restrictions indicated in Section 3					
<b>SECTION 3 – Doctor's estimate of physical capabilities – restrictions ordered are in effect for home and/or work activity</b>					
Physical capabilities (Related to work injury)	Not Recommended	Seldom 1-5%	Occasional 6-33%	Frequent 34-66%	Constant 67-100%
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand/Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb (Ladders/Stairs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend/Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat/Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach (Left, Right, Both)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work above shoulders (L, R, B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist (L, R, B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasp (L, R, B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine manipulation (L, R, B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate foot controls (L, R, B)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/Pushing	Not Recommended	Seldom	Occasional	Frequent	Constant
Lift (L, R, B)	lbs	lbs	lbs	lbs	lbs
Carry (L, R, B)	lbs	lbs	lbs	lbs	lbs
Push/Pull	lbs	lbs	lbs	lbs	lbs
Restrictions are in effect until					
Other instructions and/or limitations					
Restrictions based upon <input type="checkbox"/> Workability <input type="checkbox"/> Functional capacity assessment <input type="checkbox"/> Physical exam					
<b>SECTION 4 – Follow-up plan</b>					
<input type="checkbox"/> Next visit with this provider		<input type="checkbox"/> Consult/referral		<input type="checkbox"/> Medication prescribed	
Has function increased due to opioid therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>SECTION 5 – Maximum medical improvement (MMI) – Permanent partial impairment (PPI)</b>					
Is recovery complete? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the injured employee reached MMI? <input type="checkbox"/> Yes <input type="checkbox"/> No Date					
If yes, is it likely that the PPI will be greater than 14% whole body? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
<b>SECTION 6 – Release of information/fraud warning/signature</b>					
By signing this form I acknowledge that I have read the fraud warning and release of information on the reverse side of this form. I understand that falsifying this claim or making a false statement regarding this claim may be a felony, punishable by substantial fines and imprisonment. I authorize the release of information and agree that statements in this form are true and accurate.					
Physician's signature		Facility		Telephone number	
Injured employee's signature		Date signed		<b>C3</b>	

\* In compliance with the Federal Privacy Act of 1974, disclosure of the Social Security number on this form is mandatory pursuant to N.D.C.C. § 65-05-02. The Social Security number is used for identification and verification purposes. Failure to provide this information may result in a delay in processing your request.

**Release of information**

I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including all prior records as well as those pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS-related illness. I authorize healthcare providers to respond to WSI regarding my injury, including request for conclusions and opinions not otherwise contained within existing medical records.

In addition, I authorize any education agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S 21 Sec. 1232g. This authorization continues while I have any claim open or pending before WSI. WSI is exempt from HIPAA regulations. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.

**Fraud warning**

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers' compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with WSI, including injured employees, employers, medical providers, and attorneys.