CAPABILITY ASSESSMENT

CLAIMS DIVISION

SFN 58550 (03/2024)

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

SECTION 1 – *General information - completion of this section is required*

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

SECTION 2 – *Medical assessment*

Diagnosis code/ICD-10 code	Date of visit	Body part(s) injured	Purpose of visit
			☐ Initial evaluation ☐ Re-check ☐ Discharge

Before this injury, did the employee have any problems, injuries, or treatment to the injured body part? ☐ Yes ☐ No

Injured employee is released to work with ☐ No restrictions ☐ The restrictions indicated in Section 3

SECTION 3 – *Doctor's estimate of physical capabilities – restrictions ordered are in effect for home and/or work activity*

Physical capabilities (Related to work injury)	**Not Recommended**	**Seldom 1-5%**	**Occasional 6-33%**	**Frequent 34-66%**	**Constant 67-100%**
Sit	☐	☐	☐	☐	☐
Stand/Walk	☐	☐	☐	☐	☐
Climb (Ladders/Stairs)	☐	☐	☐	☐	☐
Twist	☐	☐	☐	☐	☐
Bend/Stoop	☐	☐	☐	☐	☐
Squat/Kneel	☐	☐	☐	☐	☐
Crawl	☐	☐	☐	☐	☐
Reach (**L**eft, **R**ight, **B**oth)	☐	☐	☐	☐	☐
Work above shoulders (**L, R, B)**	☐	☐	☐	☐	☐
Wrist (**L, R, B)**	☐	☐	☐	☐	☐
Grasp (**L, R, B)**	☐	☐	☐	☐	☐
Fine manipulation (**L, R, B)**	☐	☐	☐	☐	☐
Operate foot controls (**L, R, B)**	☐	☐	☐	☐	☐
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 ☐ Workability ☐ Functional capacity assessment ☐ Physical exam

SECTION 4 – *Follow-up plan*

☐ Next visit with this provider ☐ Consult/referral ☐ Medication prescribed

Has function increased due to opioid therapy? ☐ Yes ☐ No

SECTION 5 – *Maximum medical improvement (MMI) – Permanent partial impairment (PPI)*

Is recovery complete? ☐ Yes ☐ No

Has the injured employee reached MMI? ☐ Yes ☐ No Date

If yes, is it likely that the PPI will be greater than 14% whole body? ☐ Yes ☐ No ☐ Unknown

SECTION 6 – *Release of information/fraud warning/signature*

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**	**C3**

* 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.