Medical Limitation Report

FORM M-17
form created 1/30/03

Patient's Name:________________________________

The following medical or other limitations relate specifically to the above named patient.

1. Use of hand(s) -(__) Both (__) Right Only (__) Left Only (__) None .
2. Amount of Hours hand(s) can be used daily - Right hand ______ Left hand _______.
3. Use of Arm(s) - (__) Both (__) Right Only (__) Left Only (__) None .
4. Amount of hours arm(s) can be used daily - Right Arm ______ Left Arm _______.
5. Reaching above Shoulders - (__) Both (__) Right Arm (_) Left Arm (_) None.
6. Amount of Hours allowed reaching above shoulders daily - (________) Right Arm (_________) Left Arm
7. Standing --- (___) Yes (___) No .
8. Amount of hours allowed standing daily - Specify __________________.
9. Operating a motor vehicle --- (___) Yes (___) No .
10. Amount of hours allowed operating motor vehicle daily - Specify ___.
11. Sitting on chair --- (___) Yes (___) No .
12. Sitting on Rest Bar --- (___) Yes (___) No .
13. Amount of Hours allowed sitting daily - Chair _____ Rest Bar _____ .
14. Amount of hours allowed bending daily --- Specify ______________.
15. Amount of Hours allowed stooping daily --- Specify _______________.
16. Amount of hours allowed walking daily --- Specify ________________.
17. Amount of hours allowed pushing daily --- Specify ________________.
18. Amount of pounds that may be pushed --- Specify ________________.
19. Amount of hours allowed pulling daily --- Specify ____________.
20. Amount of pounds that may be pulled --- Specify ________________.
21. Amount of hours allowed lifting daily --- Specify ____________.
22. Amount of pounds allowed lifting daily --- Specify ______________.
23. Amount of hours allowed climbing stairs daily ---Specify___________.
24. Amount of hours allowed climbing ladder daily ---Specify __________.
25. Amount of hours allowed twisting daily --- Specify _____________.
26. Other Limitations ---

____ _______________

Attending Physician's or Health Care Provider's Signature **Date**

Received by U.S.P.S. Supervisor: ______________________________ Date: __________

FORM CREATED BY DAVE DUNKLE