MEDICAL SOURCE STATEMENT (PHYSICAL)
For Treating Physician To Complete

NAME: _____ SSN: _____

Diagnosis: _____

_____

INDICATE CURRENT LIMITATIONS FROM THE ABOVE IMPAIRMENT(S)

Occasionally Lift/Carry/Upward Pull For Not More Than 1/3 Of An 8-Hour Day (Cumulative, Not Continuous) A Maximum Of:

[ ]Less Than 10 lbs. [ ]10 lbs. [ ]20 lbs. [ ]50 lbs. [ ]100+ lbs.

Frequently Lift/Carry/Upward Pull For A Total Of 1/3 To 2/3 Of An 8-Hour Day:

[ ]Less Than 10 lbs. [ ]10 lbs. [ ]20 lbs. [ ]50+ lbs.

Stand/Walk (With Normal Breaks) For A Total Of In An 8-Hour Day:

[ ]Less Than 2 Hours [ ]At Least 2 Hours

[ ]About 6 Hours [ ]Assistive Device Needed

Sit Continuously (With Normal Breaks) During An 8-Hour Day:

[ ]Less Than 6 Hours [ ]About 6 Hours [ ]Must Alternate

Push/Pull (Including Operation Of Hand And/Or Foot Controls):

[ ]Unlimited (Other Than As Show Above)

Upper Extremities: [ ]Left [ ]Right [ ]Mild [ ]Moderate [ ]Severe

Lower Extremities: [ ]Left [ ]Right [ ]Mild [ ]Moderate [ ]Severe

Indicate any other work-related limitations, including those resulting from pain or prescribed medication.

_____

_____

How long have the above limitations existed? _____

How many hours per month would the above limitations likely disrupt a regular job schedule with low physical demands? _____

I understand that the above information will be used in consideration for Social Security benefits. I understand that making a false statement or representation herein may subject me to criminal prosecution for fraud.

Print Last Name	Physician Signature	Title	Date