Form Approved
OMB NO.0960-0431

PHYSICAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

Claimant: SSN:

Number Holder(If CDB Claim): Please indicate the earliest date the restrictions apply under other

Primary Diagnosis:	RFC Assessment Is For:
Secondary Diagnosis:	☐ Current Evaluation
Other Alleged Impairments:	☐ Date Last Insured:
	☐ Date 12 Months After Onset:
	☐ Other(Specify):

PRIVACY ACT/PAPERWORK ACT NOTICE: The information requested on this form is authorized by Section 223 and Section 1633 of the Social Security Act. The information provided will be used in making a decision on this claim. Failure to complete this form may result in a delay in processing the claim Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws S requiring the exchange of information between Social Security and other agencies.
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TIME IT TAKES TO COMPLETE THIS FORM: We estimate that it will take you about 20 minutes to complete this form. This includes the time it will take to read the instructions. gather the necessary facts and fill out the form. If you have comments or suggestions on this estimate, write to the Social Security Administration, ATTN: Reports Clearance Officer. 1 -A-2 1 Operations Bldg., Baltimore, MD 21235-0001 Send only comments relating to our "time it takes" estimate to the office listed above All requests for Social Security cards and other claims-related information should be sent to your local Social Security office, whose address is listed under Social Security Administration in the U.S. Government section of your telephone directory.

I. LIMITATIONS:

For Each Section A - F

⇒ Base your conclusions on all evidence in file (clinical and laboratory findings; symptoms; observations; lay evidence; reports of daily activities; etc.).

⇒ Check the blocks which reflect your reasoned judgment.

⇒ Describe how the evidence substantiates your conclusions (Cite specific clinical and laboratory findings, observations, lay evidence, etc.

⇒ Ensure that you have requested:

- Appropriate treating and examining source statements regarding the individual's capacities (DI 22505.000ff. and DI 22510.000ff.) and that you have given appropriate weight to treating source **conclusions.** (See Section III.)
- Considered and responded to any **alleged limitations imposed by symptoms** (pain, fatigue, etc.) attributable, in your judgment, to a medically determinable impairment. Discuss your assessment of symptom- related limitations in the explanation for your conclusions in A - F below. (See also Section II.)
- Responded to all allegations of physical limitations or factors which can cause physical limitations.

⇒ **Frequently** means occurring one-third to two-thirds of an 8-hour workday (cumulative, not continuous). **Occasionally means** occurring from very little up to one-third of an 8-hour work day (cumulative, not continuous).

A. EXERTIONAL LIMITATIONS

☐ None established. (Proceed to section B.)

1. **Occasionally** lift and/or carry (including upward pulling) (maximum)-when less than one-third of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

☐ less than 10 pounds
☐ 10 pounds
☐ 20 pounds
☐ 50 pounds
☐ 100 pounds or more

2. **Frequently** lift and/or carry (including upward pulling) (maximum)-when less than two-thirds of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

☐ less than 10 pounds
☐ 10 pounds
☐ 25 pounds
☐ 50 pounds or more

3. Is STANDING and/or WALKING affected by impairments?

☐ No ☐ Yes Medical findings that support assessment:

If YES, how many hours/minutes in an 8-hour workday can the individual stand and/or walk? Total _____

Without interruption: Total _____

4. Is SITTING affected by impairments?

☐ No ☐ Yes Medical findings that support assessment:

If YES, how many hours/minutes in an 8-hour workday can the individual sit? Total _____

Without interruption: Total _____

5. Push and/or pull (including operation of hand and/or foot controls)-
☐ unlimited, other than as shown for lift and/or carry
☐ limited in upper extremities (describe nature and degree)
☐ limited in lower extremities (describe nature and degree)

6. Explain how and why the evidence supports your conclusions in item 1 through 5. Cite the specific facts upon which your conclusions are based.

7. Is there a need to lie down, if yes, how frequently?

B. POSTURAL LIMITATIONS

☐ None established. (Proceed to section C.)

	Frequently	Occasionally	Never
1. Climbing-ramp/stairs ladder/rope/scaffolds	☐	☐	☐
2. Balancing	☐	☐	☐
3. Stooping	☐	☐	☐
4. Kneeling	☐	☐	☐
5. Crouching	☐	☐	☐
6. Crawling	☐	☐	☐

7. When less than two-thirds of the time for frequently or less than one-third for occasionally, fully describe and explain. Also explain how and why the evidence supports your conclusions in items 1 through 6. Cite the specific facts upon which your conclusions are based.

C. MANIPULATIVE LIMITATIONS

☐ None established. (Proceed to section D.)

	LIMITED	UNLIMITED
1. Reaching all directions (including overhead)	☐	☐
2. Handling (gross manipulation)	☐	☐
3. Fingering (fine manipulation)	☐	☐
4. Feeling (skin receptors)	☐	☐

5. Describe how the activities checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions in item 1 through 4. Cite the specific facts upon which your conclusions are based.

D. VISUAL LIMITATIONS

☐ None established. (Proceed to section E.)

	LIMITED	UNLIMITED
1. Near acuity	☐	☐
2. Far acuity	☐	☐
3. Depth perception	☐	☐
4. Accommodation	☐	☐
5. Color vision	☐	☐
6. Field of vision	☐	☐

7. Describe how the faculties checked "limited" are impaired. Also explain how and why the evidence supports your conclusions in item 1 through 6. Cite the specific facts upon which your conclusions are based.

E. COMMUNICATIVE LIMITATIONS

☐ None established. (Proceed to section F.)

	LIMITED	UNLIMITED
1. Hearing	☐	☐
2. Speaking	☐	☐

3. Describe how the faculties checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions in items 1 and 2. Cite the specific facts upon which your conclusions are based.

F. ENVIRONMENTAL LIMITATIONS

☐ None established. (Proceed to section II.)

	UNLIMITED	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
1. Extreme cold	☐	☐	☐	☐
2. Extreme heat	☐	☐	☐	☐
3. Wetness	☐	☐	☐	☐
4. Humidity	☐	☐	☐	☐
5. Noise	☐	☐	☐	☐
6. Vibration	☐	☐	☐	☐
7. Fumes, odors, dusts, gases, poor ventilation, etc.	☐	☐	☐	☐
8. Hazards(machinery, heights, etc.)	☐	☐	☐	☐

9. Describe how these environmental factors impair activities and identify hazards to be avoided. Also, explain how and why the evidence supports your conclusions in items 1 though 8. Cite the specific facts upon which your conclusions are based.

G. Monthly Work Limitations

In an average work month (approx. 30 days), do you believe that this patient would miss any days due to his or her impairments?

_____ YES _____ NO

If you answered YES, how many days do you believe he or she will miss from work?

No. of days: _____

Please explain:

Would the individual need to lie down during a normal 8 hour workday?

Yes____ No____

If "YES, in your estimation, how much time would the individual need to lie down in a workday?

_____ Hours _____ Minutes

ADDITIONAL COMMENTS:

☐ These findings complete the medical portion of the disability determination.

MEDICAL CONSULTANT'S SIGNATURE: MEDICAL CONSULTANT'S CODE: DATE:

Signature _____

Print Name _____

Form SSA-4734BK (1-89)
(Formerly SSA-4734-U8 Use prior editions)