Mental Capacities

Name: Date of Birth:

Based on your assessment of the individual, are they able to work on a regular and sustained basis specific to their mental capacities?

☐ Yes ☐ No

Based on your assessment of the individual, are they able to work an eight-hour workday?

☐ Yes ☐ No

If No, how many hours per day is this individual able to work? _____

Based upon your assessment of the individual, please indicate the level of functioning in the associated category, using the definitions provided below:

None: There are no limitations.
Mild: There are limitations on ability to function, but they are mild or transient.
Moderate: The ability to function in this area is less than severe, but more than mild.
Severe: The ability to function in this area is seriously limited.
Extreme: The ability to function in this area is precluded and cannot be done.

In an eight-hour workday, the individual can perform the following activities:	**Limitation Level:**				
	None	**Mild**	**Moderate**	**Severe**	**Extreme/ cannot do**
Ability to understand simple instructions.					
Ability to carry out simple instructions.					
Ability to understand detailed instructions.					
Ability to carry out detailed instructions.					
Ability to remember locations and work procedures.					
Ability to maintain attention and concentration for extended periods (more than 10 minutes).					
Ability to work within a schedule, maintain attendance and be punctual.					
Ability to work with others without being distracted by them.					
Ability to work with others without being a distraction to them.					
Ability to make simple, work-related decisions.					
Ability to work effectively with customers/clients.					

Ability to tolerate daily stress without feeling overwhelmed.					

If there are **OTHER** medical facts, situational factors, equipment, or devices that need to be considered to identify a position for this person, please explain:

_____

_____

_____

If applicable, please identify other limitations that may impact this person's ability to work:

_____

_____

_____

_____ _____

Health Care Provider's Signature Date

_____ _____

Health Care Provider's Address Office Phone Number