Form Approved
OMB NO.0960-0431

PHYSICAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

Claimant: SSN:**000-00-0000**

Number Holder(If CDB Claim):

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

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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. I -A-2 I 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.OOOff. and DI 22510.OOOff.) 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). Occasi**onally means** occurring from very little up **to** one-third of an 8-hour workday (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. Stand and/or walk (with normal breaks) for a total of:
☐ less than 2 hours in an 8-hour workday
☐ at least 2 hours in an 8-hour workday
☐ about 6 hours in an 8-hour workday

☐ medically required hand-held assistive device is necessary for ambulation

4. Sit (with normal breaks) for a total of
☐ less than about 6 hours in an 8-hour workday
☐ about 6 hours in an 8-hour workday

☐ must periodically alternate sitting and standing to relieve pain or discomfort. (If checked, explain in 6.)

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.

6. Continue (note: make additional comments in section IV)

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.

9. Continue (note: make additional comments in section IV)

II. SYMPTOMS

For symptoms alleged by the claimant to produce physical limitations, and for which the following have not previously been addressed in section I, discuss whether:

A. The symptom(s) is attributable, in your judgment, to a medically determinable impairment.

B. The severity or duration of the symptom(s), in your judgment, is disproportionate to the expected severity or expected duration on the basis of the claimant's medically determinable impairment(s).

C. The severity of the symptom(s) and its alleged effect on function is consistent, in your judgment, with the total medical and nonmedical evidence, including statements by the claimant and others, observations regarding activities of daily living, and alterations of usual behavior or habits.

III. TREATING OR EXAMINING SOURCE STATEMENT(S)

A. Is a treating or examining source statement(s) regarding the claimant's physical capacities in file?

☐ Yes

☐ No (Includes situations in which there was no source or when the source(s) did not provide a statement regarding the claimant's physical capacities.)

B. If yes, are there treating/examining source conclusions about the claimant's limitations or restrictions which are significantly different from your findings?

☐ Yes

☐ No

C. If yes, explain why those conclusions are not supported by the evidence in file. (Cite the source's name and the statement date.)

IV. ADDITIONAL COMMENTS:

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

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

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0MB No 0960-0431

MENTAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

Name: SSN:**000-00-0000**

Categories(From 1B of the PRFT)	Assessment Is For:
	☐ Current Evaluation
	☐ Date Last Insured: / /
	☐ Date 12 Months After Onset: / /
	☐ Other(Specify):

I. SUMMARY CONCLUSIONS

This section is for recording summary conclusions derived from the evidence in file. Each mental activity is to be evaluated within the context of the individual's capacity to sustain that activity over a normal workday and workweek, on an ongoing basis. Detailed explanation of the degree of limitation for each category (A through D), as well as any other assessment information you deem appropriate, is to be recorded in Section III (Functional Capacity Assessment).

If rating category 5 is checked for any of the following items, you MUST specify in Section II the evidence that is needed to make the assessment. If you conclude that the record is so inadequately documented that no accurate functional capacity assessment can be made, indicate in Section II what development is necessary, but DO NOT COMPLETE SECTION III.

		Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Ratable on Available Evidence
A.	**UNDERSTANDING AND MEMORY**					
1.	The ability to remember locations and work-like procedures	☐	☐	☐	☐	☐
2.	The ability to understand and remember very short and simple instructions	☐	☐	☐	☐	☐
3.	The ability to understand and remember detailed instructions.	☐	☐	☐	☐	☐
B.	**SUSTAINED CONCENTRATION AND PERSISTENCE**					
4.	The ability to carry out very short and simple instructions	☐	☐	☐	☐	☐
5.	The ability to carry out detailed instructions.	☐	☐	☐	☐	☐
6.	The ability to maintain attention and concentration for extended periods.	☐	☐	☐	☐	☐
7.	The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances	☐	☐	☐	☐	☐
8.	The ability to sustain an ordinary routine without special supervision	☐	☐	☐	☐	☐
9.	The ability to work in coordination with or proximity to others without being distracted by them	☐	☐	☐	☐	☐
10.	The ability to make simple work-related decisions.	☐	☐	☐	☐	☐

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Formerly SSA-4734-F4-SUP1

		Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Ratable on Available Evidence
11.	The ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	☐	☐	☐	☐	☐
C.	**SOCIAL INTERACTION**					
12.	The ability to interact appropriately with the general public	☐	☐	☐	☐	☐
13.	The ability to ask simple questions or request assistance	☐	☐	☐	☐	☐
14.	The ability to accept instructions and respond appropriately to criticism from supervisors	☐	☐	☐	☐	☐
15.	The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.	☐	☐	☐	☐	☐
16.	The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	☐	☐	☐	☐	☐
D.	**ADAPTATION**					
17.	The ability to respond appropriately to changes in the work setting.	☐	☐	☐	☐	☐
18.	The ability to be aware of normal hazards and take appropriate precautions	☐	☐	☐	☐	☐
19.	The ability to travel in unfamiliar places or use public transportation.	☐	☐	☐	☐	☐
20.	The ability to set realistic goals or make plans independently of others	☐	☐	☐	☐	☐

II. REMARKS: If you checked box 5 for any of the preceding items or if any other documentation deficiencies were identified, you MUST specify what additional documentation is needed. Cite the item number(s), as well as any other specific deficiency, and indicate the development to be undertaken.

III. FUNCTIONAL CAPACITY ASSESSMENT

Record in this section the elaborations on the preceding capacities. Complete this section ONLY after the SUMMARY CONCLUSIONS section has been completed. Explain your summary conclusions in narrative form. Include any information which clarifies limitation or function. Be especially careful to explain conclusions that differ from those of treating medical sources or from the individual's allegations.

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

MEDICAL CONSULTANT'S SIGNATURE DATE

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