FORM APPROVED
OMB NO. 0960-0431

RESIDUAL PHYSICAL FUNCTIONAL CAPACITY ASSESSMENT

CLAIMANT:	SOCIAL SECURITY NUMBER:
NUMBERHOLDER (IF CDB CLAIM):	

	RFC ASSESSMENT IS FOR:
PRIMARY DIAGNOSIS:	☐ Current Evaluation ☐ Date 12 Months After Onset: ______ (Date)
SECONDARY DIAGNOSIS:	☐ Date Last Insured: ______ (Date)
OTHER ALLEGED IMPAIRMENTS:	☐ Other (Specify): ______

Paperwork/Privacy 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 requiring the exchange of information between Social Security and other agencies.

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 omments or suggestions on this estimate, write to the Social Security Administration, ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235. Send only comments relating to our estimate or other aspects of this form 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:

- Apropriate 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 workday (cumulative, not continuous).

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