Work/Training Tolerance Assessment

Individual's Name:_____

	Yes	No	Comments
Can physically tolerate full day of work or training? (Sitting, standing, lifting, carry, bending, reaching, etc.) Please specify.	☐	☐	
Can emotionally tolerate full day of work or training? (Noise, people, light, stress of social interaction, etc.) Please specify.	☐	☐	
Can tolerate half day of work or training? If not how long can the individual tolerate work or training?	☐	☐	
Is affected by environmental factors that make it difficult for the individual to participate in a full day of work or training? (Allergies, asthma, temperature (cold, hot), chemical sensitivities, etc.)	☐	☐	
Can tolerate carrying items while being mobile?	☐	☐	
Does the individual take any medication that may affect driving or working in the heat, sun or cold?	☐	☐	
Other:			

Medical/disability restrictions that would affect this individual's tolerance:

Potential Tolerance Adaptations/Recommendations

Evaluations:

Wheelchair Device:

Walkers or Canes:

Clear Form

Work/Training Tolerance Assessment

Prosthesis:

Other:

Training:

Use of Adaptive Equipment:

Other:

Equipment:

Wheelchair Device:

Adaptive Seating and Positioning Devices:

Hands Free Phone System:

Electronic Communication:

Air Purifier Devices:

Clear Form

Work/Training Tolerance Assessment

Distance Learning:

Ear plugs:

Recorded Materials:

Talking Word Processor:

Adapted Computer System:

Adapted Software:

Signature Stamp:

Rolling Backpack:

Cart with Wheels:

Clear Form

Work/Training Tolerance Assessment

Other:

EC Name: _____ Date: _____

Clear Form