Carleton University

FUNCTIONAL ABILITIES FORM (Physical)

In support of a safe return to work

CONFIDENTIAL

Complete this form and return it to the address on the contact on the last page

Completed by the Employee

Name:_____ Employee ID Number:_____

Last day worked:_____ Job title:_____

Authorization: I authorize any Health Professional involved with my treatment to provide my employer with this form when completed, containing information including any medical limitations/restrictions related to my ability to return to work or perform my assigned duties.

Employee Signature: Date:_____

A -Completed by the Treating Health Practioner

Complete all relevant sections and provide as much detail as possible. **Missing information will require the employer to follow-up.** Please reference any job description, physical demands analysis or job summary that has have been provided in determining any restrictions.

☐ Normal Functional Abilities – Fit for regular duties. Skip to end (**Section G-Signature)**

☐ Reduced Functional Abilities (please also complete applicable sections: **B - Musculoskeletal, C - Work Environment, D-Return to Work and Scheduling, E - Estimated Duration of Limitations, F - Signature**)

Date of commencement of illness: _____ Most recent examination date: _____

Prognosis for recovery:_____

Has this employee been referred to a specialist? ☐ No ☐ Yes (specify date)_____

Is the illness being treated work-related? ☐ No ☐ Yes (details)_____

_____

Are you aware of any work-related issues that may have a negative effect on the employee's present medical condition?

☐ Yes ☐ No (details)_____

Is the employee taking medication that impacts their ability to perform the essential duties of their job? ☐ Yes

(please specify)_____

B -Musculoskeletal functional abilities

Please identify and detail limitations/restrictions (%, kg, degree, repetition, as applicable, etc.)

Neck:	
Shoulder:	
Elbow:	
Wrist/Hand:	
Finger:	
Back:	
Hip:	
Knee:	

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Walking: ☐ Full abilities ☐ Other: _____
Standing: ☐ Full abilities ☐ Other: _____
Sitting: ☐ Full abilities ☐ Other:_____
Lifting from floor to waist: ☐ Full abilities ☐ Other: _____
Lifting from waist to shoulder: ☐ Full abilities ☐ Other: _____
Lifting from above shoulder: ☐ Full abilities ☐ Other: _____

Other:_____

Stair climbing: ☐ Full abilities ☐ Other:_____
Ladder climbing: ☐ Full abilities ☐ Other: _____

Difficulty in: ☐ Bending/twisting repetitive movement of:_____
☐ Working at or above shoulder activity: _____

Limited pushing/pulling with: ☐ Not applicable ☐ Left arm ☐ Right arm ☐ Other: _____

Limited use of hand(s) or wrist(s): ☐ Not applicable
Typing/keyboard use: ☐ Left ☐ Right Writing: ☐ Left ☐ Right Gripping: ☐ Left ☐ Right Pinching: ☐ Left ☐ Right
☐ Other: _____ ☐ Left ☐ Right

Difficulty in: ☐ Not applicable
☐ Operating motorized equipment: _____ ☐ Operating machinery: _____
☐ Working at heights: _____ ☐ Situation Sensitivity:_____
☐ Chemical Exposure to:_____ ☐ Environmental conditions: _____
☐ Exposure to vibration: _____

Musculoskeletal Functional comments

Please also complete Sections C, D, E, and F

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C-Work Environment

Please indicate any situations/settings from which the worker is restricted.

- ☐ Working within an office environment
- ☐ Settings, involving high level of social interaction
- ☐ Setting which require strenuous activity
- ☐ Working around heavy machinery
- ☐ Working within a healthcare setting
- ☐ Working within security
- ☐ Travelling in a vehicle to a remote work site or on the job
- ☐ Settings where there is access to substance of abuse
- ☐ Exposure to trauma triggers (please specify) _____
- ☐ Chemical exposure to _____
- ☐ Environmental exposure to _____
- ☐ Other (please explain) _____

Comments

D-Return to Work and Scheduling

Schedule Restrictions

- ☐ Unable to work rotating shifts
- ☐ Unable to work night shifts
- ☐ Unable to work morning shifts
- ☐ Unable to work prolonged workdays
- ☐ Unable to work overtime

Graduated Return to Work Recommendations

I recommend the employee begins working _____ hours per day, _____ days per week, starting _____

The schedule should increase by _____ hours per day each week. This plan would have the employee back to full hours by _____.

E-Estimated Duration of Limitations

☐ _____ days ☐ 2-4 weeks ☐ 4-6 weeks ☐ 8-10 weeks ☐ Permanent

Additional Comments

F-Signature of Treating Health Practitioner

☐ No reassessment anticipated ☐ I recommend a reassessment of capabilities on _____

I have provided this completed Functional Abilities form to the employee ☐ Yes ☐ No

☐ I have not discussed Return to Work with the employee (specify reason):

_____

_____ _____
Signature Profession

_____ _____
Name Date

Return completed form to

Attention: _____

Email to MedicalLeave@cunet.carleton.ca

or fax to 343-688-1411