

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:	

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: _____

Working at heights: _____

Chemical Exposure to: _____

Exposure to vibration: _____

Operating machinery: _____

Situation Sensitivity: _____

Environmental conditions: _____

Musculoskeletal Functional comments

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

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

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
- Exposure to trauma triggers (please specify) _____
- Chemical exposure to _____
- Environmental exposure to _____
- Other (please explain) _____
- 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

Comments

D-Return to Work and Scheduling

Is the employee ready to commence a Return to Work: Yes No If no, skip to **section F.**

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

Note: If there is a fee associated with the completion of this form, Carleton will reimburse to a maximum of \$100.00

Return completed form to _____

Attention: _____

Email to MedicalLeave@cunet.carleton.ca

or fax to 343-688-1411