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| ***Employee Group:*** | ***Requested By:*** |
| ***WSIB Claim: Yes No*** | ***WSIB Claim Number:*** |

**To the Employee**: The purpose for this form is to provide the Board with information to assess whether you are able to perform the essential duties of your position, and understand your restrictions and/or limitations to assess workplace accommodation if necessary.

***Employee’s Consent***: I authorize the Health Professional involved with my treatment to provide to my employer this form when complete. This form contains information about any medical limitations/restrictions affecting my ability to return to work or perform my assigned duties.

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| **Employee Name:***(Please print)* | **Employee Signature:** |
| **Employee ID:** | **Telephone No:** |
| **Employee Address:** | **Work Location:** |
| **1. Health Care Professional: The following information should be completed by the Health Care Professional** |
| Please check one:Patient is capable of returning to work with no restrictions. |
| Patient is capable of returning to work with restrictions. **Complete section 2 (A & B) & 3** |
| I have reviewed sections 2 (A & B) and have determined that the Patient is totally disabled and is unable to return to work at this time.**Complete sections 3 and 4. Should the absence continue, updated medical information will next be requested after the date of the follow up appointment indicated in section 4.** |
| First Day of Absence: | General Nature of Illness (***please do not include diagnosis***): |
| Date of Assessment: | dd | mm | yyyy |  |  |
| **2A: Health Care Professional to complete. Please outline your patient’s abilities and/or restrictions based on your objective medical findings.** |
| **PHYSICAL (if applicable)** |
| **Walking:**Full AbilitiesUp to 100 metres 100 - 200 metresOther (*please specify*): | **Standing:**Full AbilitiesUp to 15 minutes 15 - 30 minutesOther (*please specify*): | **Sitting:**Full AbilitiesUp to 30 minutes 30 minutes - 1 hourOther (*please specify*): | **Lifting from floor to waist:**Full AbilitiesUp to 5 kilograms 5 - 10 kilogramsOther (*please specify*): |
| **Lifting from Waist to Shoulder:**Full abilitiesUp to 5 kilograms 5 - 10 kilogramsOther (*please specify*): | **Stair Climbing:** Full abilities Up to 5 steps 6 - 12 stepsOther (*please specify*): | **Use of hand(s): Left Hand**Gripping PinchingOther (*please specify*): | **Right Hand** Gripping PinchingOther (*please specify*): |

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| **Bending/twisting** repetitive movement of (*please specify*): | **Work at or above shoulder activity**: | **Chemical exposure to**: | **Travel to Work**:Ability to use public transitAbility to drive car |  | Yes Yes | No No |
| **2B: COGNITIVE (*please complete all that is applicable*)** |
| **Attention and Concentration:**Full Abilities Limited Abilities Comments: | **Following Directions:** Full Abilities Limited Abilities Comments: | **Decision- Making/Supervision:**Full Abilities Limited Abilities Comments: | **Multi-Tasking:** Full Abilities Limited Abilities Comments: |
| **Ability to Organize:** Full Abilities Limited Abilities Comments: | **Memory:**Full Abilities Limited Abilities Comments: | **Social Interaction:** Full Abilities Limited Abilities Comments: | **Communication:** Full Abilities Limited Abilities Comments: |
| Please identify the assessment tool(s) used to determine the above abilities *(Examples: Lifting tests, grip strength tests, Anxiety Inventories, Self-Reporting, etc.* |
| Additional comments on **Limitations (not able to do) and/or Restrictions (should/must not do) for all medical conditions**: |
| **3: Health Care Professional to complete.** |
| From the date of this assessment, the above will apply for approximately:6-10 days 11- 15 days 16- 25 days 26 + days | Have you discussed return to work with your patient?Yes No |
| Recommendations for work hours and start date (if applicable):Regular full time hours Modified hours Graduated hours | Start Date: |  |  |  | dd | mm | yyyy |  |
| Is patient on an active treatment plan?: Yes NoHas a referral to another Health Care Professional been made?Yes (optional - please specify): If a referral has been made, will you continue to be the patient’s primary Health Care Provider? | No | Yes |  |  | No |  |  |
| 4: Recommended date of next appointment to review Abilities and/or Restrictions: |  |  | dd |  | mm | yyyy |  |

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| **Completing Health Care Professional Name:****(Please Print)** |  |
| **Date:** |  |
| **Telephone Number:** |  |
| **Fax Number:** |  |
| **Signature:** |  |
|  |  |

Please return this form to your patient to forward to our confidential fax # **519-370-6640 or scan document and email to** **kathy\_eccles@bwdsb.on.ca,** **Employee Support HR**

Personal information on this form is collected under the authority of the Education Act, R.S.O. 1990, C.E.2, Bluewater District School Board’s Accommodation in the Workplace/Return to Work Program, and when work related, the Workplace Safety and Insurance Act, 1997, and will be used to determine an employee’s functional abilities for return to work purposes. Questions about this collection should be referred to the Administrator of Employee Relations, (519) 363-2014.

*Thank you for your assistance in supporting our valued employee.* Rev 2015.12