



BLUEWATER DISTRICT SCHOOL BOARD FUNCTIONAL ABILITY FORM

Employee Group:	Requested By:
WSIB Claim: <input type="checkbox"/> Yes <input type="checkbox"/> 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.

Employee Name: <i>(Please print)</i>	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 (<i>please do not include diagnosis</i>): _____
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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: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 100 metres <input type="checkbox"/> 100 - 200 metres <input type="checkbox"/> Other (<i>please specify</i>):	Standing: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15 - 30 minutes <input type="checkbox"/> Other (<i>please specify</i>):	Sitting: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 minutes - 1 hour <input type="checkbox"/> Other (<i>please specify</i>):	Lifting from floor to waist: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (<i>please specify</i>):								
Lifting from Waist to Shoulder: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (<i>please specify</i>):	Stair Climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 steps <input type="checkbox"/> 6 - 12 steps <input type="checkbox"/> Other (<i>please specify</i>):	<input type="checkbox"/> Use of hand(s): <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Left Hand</td> <td style="width: 50%; border: none;">Right Hand</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Gripping</td> <td style="border: none;"><input type="checkbox"/> Gripping</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Pinching</td> <td style="border: none;"><input type="checkbox"/> Pinching</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Other (<i>please specify</i>):</td> <td style="border: none;"><input type="checkbox"/> Other (<i>please specify</i>):</td> </tr> </table>		Left Hand	Right Hand	<input type="checkbox"/> Gripping	<input type="checkbox"/> Gripping	<input type="checkbox"/> Pinching	<input type="checkbox"/> Pinching	<input type="checkbox"/> Other (<i>please specify</i>):	<input type="checkbox"/> Other (<i>please specify</i>):
Left Hand	Right Hand										
<input type="checkbox"/> Gripping	<input type="checkbox"/> Gripping										
<input type="checkbox"/> Pinching	<input type="checkbox"/> Pinching										
<input type="checkbox"/> Other (<i>please specify</i>):	<input type="checkbox"/> Other (<i>please specify</i>):										



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<input type="checkbox"/> Bending/twisting repetitive movement of (please specify):	<input type="checkbox"/> Work at or above shoulder activity:	<input type="checkbox"/> Chemical exposure to:	Travel to Work: Ability to use public transit <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> Ability to drive car <input type="checkbox"/> Yes <input type="checkbox"/> No
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2B: COGNITIVE (please complete all that is applicable)

Attention and Concentration: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Following Directions: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Decision- Making/Supervision: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Multi-Tasking: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:
Ability to Organize: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Memory: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Social Interaction: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Communication: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> 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: <input type="checkbox"/> 6-10 days <input type="checkbox"/> 11- 15 days <input type="checkbox"/> 16- 25 days <input type="checkbox"/> 26 + days	Have you discussed return to work with your patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Recommendations for work hours and start date (if applicable): <input type="checkbox"/> Regular full time hours <input type="checkbox"/> Modified hours <input type="checkbox"/> Graduated hours	Start Date: _____ <div style="text-align: right;">dd mm yyyy</div>
Is patient on an active treatment plan?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has a referral to another Health Care Professional been made? <input type="checkbox"/> Yes (optional - please specify): _____ <input type="checkbox"/> No	
If a referral has been made, will you continue to be the patient's primary Health Care Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4: Recommended date of next appointment to review Abilities and/or Restrictions: <div style="text-align: right;">dd mm yyyy</div>	

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