FUNCTION ABILITIES FORM

WE ARE COMMITTED TO ACCOMMODATING ALL INJURED WORKERS IN ANY MANNER NECESSARY INCLUDING SEDENTARY.

We thank you for your assistance and co-operation in attending to our employee and completing this form.

I hereby authorize my treating health care practitioner to consult with my employer as it pertains to facilitating my return to regular duties.

EMPLOYEE'S SIGNATURE _____

Dear Health Care Practitioner:

In order for us to fulfill our obligation to the WCB, we ask that you complete this form and have the employee return it to his/her supervisor.

LAST NAME:	**FIRST NAME:**
EMPLOYEE'S AILMENT:	

The following information should be completed by a Health Professional:

1	Date of examination on which the report is based	Area of Injury
2	Rehabilitation/Treatment Required? ☐ Yes ☐ No	Is the worker capable of returning to work immediately without restrictions? ☐ Yes ☐ No If no, please complete the next section.

Please complete where capabilities are known or limitations recommended. Note: ôas toleratedô implies that restrictions are recommended but must be quantified in the workplace.

Capabilities

Walking: short distance only ☐ as tolerated ☐ other (eg. Uneven ground) ☐

_____

Standing: less than 15 min ☐ less than 30 min ☐ as tolerated ☐ other ☐

_____

Sitting: less than 30 min ☐ less than 1 hour ☐ as tolerated ☐ other ☐

_____

Lifting floor to waist: less than 10 Kg ☐ less than 25 Kg ☐ as tolerated ☐ other ☐

_____

Lifting waist to shoulder: less than 10 Kg ☐ less than 25 Kg ☐ as tolerated ☐

other ☐ _____

Stair climbing: none ☐ 2-3 steps only ☐ short flight ☐ own pace ☐ as tolerated ☐

Ladder climbing: none ☐ 2-3 steps only ☐ 4-6 steps only ☐ own pace ☐ as tolerated ☐

Limited ability to use hand to: hold objects ☐ grip ☐ type ☐ write ☐

3 Limitations

- ☐ Bending or twisting of
- ☐ Chemical exposure to
- ☐ Operating motorized equipment
- ☐ Above-shoulder activity
- ☐ Repetitive movement of
- ☐ Environmental exposure to
- ☐ Restrictions related to medications: (specify)
- ☐ Below-shoulder activity

Exposure to vibration: high frequency ☐ low frequency ☐

Limit physical exertion to: mild ☐ moderate ☐ as tolerated ☐

General Comments/Specific Limitations

4	**Recommendation for Work Hours** ☐ Full-time hours ☐ Modified hours ☐ Graduated hours	**5**	Complete Recovery Expected? ☐ no ☐ yes	Estimated Duration of Limitations

Health Professionalôs Name (Please Print)	Health Profession	Date of Next Appointment For Review of Capabilities	dd mmm yyyy
Address	**City / Town**	**Province**	**Postal Code**
Signature	Date dd mmm yyyy	Area Code ( )	Telephone