ST. JOSEPH'S CARE GROUP

Functional Abilities Form for Timely Return to Work

Employee Name: _____ Phone #: _____ D.O.B. _____

Job Title: _____ Manager: _____

Authorization for Release of Information:
I authorize the physician/practitioner to give documentation of my current medical condition to Occupational Health Services, St. Joseph's Care Group strictly for the purposes of validating my claim for total disability and managing my medical absence. I consent to allow Occupational Health & Wellness to provide information related to my fitness for work and any accommodation needs to my manager/supervisor/Human Resources and Union Representative(if applicable). A photocopy of this authorization is as valid as the original.

Employee Signature: _____ Date: _____

Nature of Illness/Injury: _____

Please complete where limitations are recommended (only where applicable):

A. Walking/Standing/Sitting					
	Unable	< 15 minutes	15 - 30	30 – 60	60 minutes
Walking					
Standing					
Sitting					
Squatting/Kneeling					

B. Lifting/Pushing/Pulling				
	Unable	*Minimal (<10%)*	*Occasional (11 0 34%)*	*Frequent (35 – 66%)*
Lifting Floor to Waist				
Sedentary/Light (<7 kg/ 15 lb)				
Medium (<14 kg/ 30 lb)				
Heavy (<25 kg/ 55 lb)				
Lifting Waist to Shoulder				
Sedentary/Light (<7 kg/ 15 lb)				
Medium (<14 kg/ 30 lb)				
Heavy (<25 kg/ 55 lb)				
Lifting Above the Shoulder				
Sedentary/Light (<7 kg/ 15 lb)				
Medium (<14 kg/ 30 lb)				
Heavy (<25 kg/ 55 lb)				
Pushing/Pulling				
Sedentary/Light (<7 kg/ 15 lb)				
Medium (<14 kg/ 30 lb)				
Heavy (<25 kg/ 55 lb)				

Please Turn Over

Employee Name: _____

C. Other Physical Restrictions			
	Minimal (<10%)	*Occasional (11 0 34%)*	*Frequent (35 – 66%)*
Gripping			
Keyboarding			
Carrying			
Reaching overhead			
Bending/Twisting (cervical/ lumbar)			
Climbing stairs/ladders			

D. Other Restrictions (if applicable):								
Shift/Hours Restrictions (please specify):								
Repetitive Movement/Use of:								
Chemical/Environmental Exposure to:								
Restrictions Related to Medications:								
Exposure to Vibrations: high frequency		low frequency						
Operating a Motor Vehicle: No Limitations		Limitations reported to the Ministry of Transportation Yes		No				
Would utilizing public transit be a feasible option? Yes		No						

E. Cognitive Restrictions (if applicable):							
No Limitations							
Coherent Yes		No					
Concentration Good		Adequate		Poor			
Judgment Good		Adequate		Poor			
Can this person work: Independently?		With Supervision?		With Assistance?			
Additional Comments:							

Date of Next Assessment:	**Date RTW Modified Work:**
Estimated Duration of Limitations:	**Date RTW Regular Job:**

B*y completing this Functional Abilities Form, the information contained herein will become part of the employee's medical file.* ***Modified work is available.*** *Please have the employee return this completed form to Occupational Health & Wellness via confidential fax number (807) 346-2353 immediately.*

Health Professional Name: _____ Health Profession: _____

Date of Next Appointment: _____ Telephone: _____

Full Address: _____ City/Town: _____ Prov.: _____

Signature: _____ Date: _____

St. Joseph's Care Group, 35 N. Algoma Street, P.O. Box 3251, Thunder Bay, ON P7B 5G7 Telephone 807-346-2341 Fax 807-346-2353