EMPLOYEE AUTHORIZATION: I authorize my physician/practitioner to complete this form for the confidential attention of the Occupational Health Department at LWHA. I agree to the release of information between my healthcare practitioner and Occupational Health to clarify the information contained on this form that will be used to address a disability decision and to process return to work/accommodation.

***PLEASE NOTE: COMPLETED FORMS MUST BE FULLY LEGIBLE OR PROCESSING DELAYS MAY OCCUR***

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| --- |
| **Section A: to be completed by worker** |
| Employee Name | Department/Position | Hospital Site |
| Employee Signature | Date of Birth | Manager |

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| **Section B: to be completed by Practitioner** |
| General nature of illness / injury: | Next appointment: |
| Date Treatment Started and Estimated Duration: | Has employee been referred to a Specialist: YES NO |

**PARTIAL DISABILITY:**

**Able to perform modified duties, meaning: own job or suitable duties of another job; include information/details in the Functional Abilities section, below. (Note: cognitive/functional capabilities must be indicated below to ensure that duties are appropriately modified).**

May return to work performing modified duties:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Estimated date to resume full duties:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| 1. **FUNCTIONAL ABILITIES (Please note – if “other” is selected, please specify)**
 |
| Walking:* Full abilities
* Up to metres
* 100-200 metres
* Other
 | Standing:* Full abilities
* Up to 15 minutes
* 15-30 minutes
* Other
 | Sitting:* Full abilities
* Up to 30 minutes
* 30 minutes to 1 hour
* Other
 | Lifting from floor to waist:* Full abilities
* Up to 5 kilograms
* 5-10 kilograms
* Other
 |
| Lifting from waist to shoulder:* Full abilities
* Up to 5 kilograms
* 5-10 kilograms
* Other
 | Stair climbing:* Full abilities
* Up to 10 steps
* Other
 | Ladder climbing:* Full abilities
* 1-3 steps
* 4-6 steps
* Other
 | Travel to work:* N/A
* Unable to drive a car
 |
|  |
| * Bending/twisting repetitive movement restrictions (specify)
 | * Work at or above shoulder activity
 | * Chemical exposure to:
 | * Environmental exposure to:
 |

continued on next page

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| --- | --- | --- | --- |
| * Limited pushing/pulling with:
	+ Left arm
	+ Right arm
	+ Other please specify
 | * Operating motorized equipment
 | * Potential side effects from medication (please specify)
 | * Limited use of hands:
* Gripping
* Pinching
* Specify which hand
 |
| Recommendations for work hours and start date: Regular full-time hours  Modified hours  Graduated hours  Start Date: |

|  |  |  |
| --- | --- | --- |
| 1. **COGNITIVE ABILITIES**

Able to follow a schedule and maintain attendance/punctuality:Yes, full abilitiesNo, not consistently (provide detail) | Deadlines:Can handle deadlines (full abilities)Can handle occasional deadlinesCannot manage deadlines | Able to perform work that is (check all that apply):Monotonous Repetitive,short cycle workVaried, with basic tasksVaried, with moderately complex tasks |
| Emotional/SocialHas no restrictionsCan work (check all that apply):In isolationAs part of a teamIn relationship building situationsSupervising othersInfluencing othersResolving conflictIn emotional/confrontational situationsIn crisis or emergency situationsWith the public/patients | Cognitive DemandsHas no restrictionsCan handle (check all that apply):Attention to detailLimited attention to detailFollowing specific instructionsSelf-supervision/autonomyAttainment of precise standardsPlanning and time managementProblem solving/decision makingInitiating action and being adaptable | Mental DemandsHas no restrictionsCan handle (check all that apply):Sustained concentration and focusPartial concentration and focusRetention of informationNew learningMulti-taskingAnalytical thinkingSound judgmentEffective written communication |
| Recommendations for work hours and start date: Regular full-time hours  Modified hours  Graduated hours  Start Date: |

**TOTAL/SUBSTANTIAL DISABILITY**

**Based on objective medical information, the employee is unable to perform the regular duties of own job as performed immediately before becoming disabled. Please note: The hospital offers a supportive accommodation/return to work program to assist employees back to work**.

Totally disabled from (date):\_\_\_\_\_\_\_\_\_\_\_\_\_to (date):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Earliest expected return to work date:\_\_\_\_\_\_\_\_\_\_\_\_

Include the limitations that contribute to total disability: \_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| Health Professional’s **Name (printed)** | Telephone |
| **Health Professional’s Signature:** | Date |