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: | | | |

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| 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 restrictions  Can 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 restrictions  Can 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 restrictions  Can 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 |