Updated December 2025

Health Care Practitioner's Statement Form

FUNCTIONAL ABILITIES FORM

In order to support the medical absence of this employee and to facilitate his/her return to work we require specific information. LWHA is committed to providing a transitional/modified work program for its personnel and we require your guidance to ensure a timely and safe return to work, in collaboration with the primary care provider, department manager/supervisor and worker.

Please submit completed form to LWHA Occupational Health via email or fax; lauren.poppe@lwha.ca or 519-357-3927(WDH)/519-292-2098(LMH)

A. *(to be completed by employee)*

Employee; **Last Name**	**First Name**	**Telephone**
Address		**Email Address**

AUTHORIZATION

I do hereby authorize _____ (healthcare provider, licensed physician, medical practitioner, hospital, clinic) to disclose my medical and health information relating to my current absence from work to ***Occupational Health or designate, LWHA***. This consent pertains to my current absence from work and/or my need for modified or accommodated work and may include the results of consultations or assessments obtained regarding my health condition. 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. *This consent is valid from the date signed until I return to full hours and duties at work, or on the date my business relationship with LWHA has been formally severed, whichever is earlier.*

_____ _____ _____

Employee Name (Printed) Employee Signature Date

B. ILLNESS / INJURY INFORMATION *(to be completed by HCP)*

Nature (but not diagnosis) of the current illness / injury: _____

Date illness/injury began for this current absence: _____

Date of examination by Physician for this current absence: _____

Anticipated length of illness: _____

Date employee expected to return to full hours / full duties: _____

Have you scheduled a follow up appointment for this current absence? ☐ Yes; ☐ No If yes, when? _____

Has a treatment plan been prescribed for the illness/injury? ☐ Yes; ☐ No If no, why? _____

Is the employee compliant with treatment? ☐ Yes; ☐ No

Is this illness/injury work related? ☐ Yes; ☐ No

If absence is due to a procedure/surgery, is the procedure/surgery covered by OHIP? ☐ Yes; ☐ No

If employee cannot return to full duties, can the employee return to work with restrictions/limitations: ☐ Yes; ☐ No

Expected duration of restrictions: _____

Partial Disability? ( ) Yes or ( ) No (Able to perform modified duties)	**May return to work with modified duties as of:**	**Expected date to resume full duties:**
Total Disability? ( ) Yes or ( ) No (unable to perform any work duties)	**Total disability date from (date):** **to (date):**	**Expected return to work date:**

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C. ***(Please note; this section is mandatory for the FAF to be accepted. Must be completed regardless of whether an employee is eligible for RTW or not.)***

FUNCTIONAL ABILITIES

Walking (continuously); ☐ Up to 30 min ☐ Up to 1 hour ☐ No restriction ☐ Other: _____ _____	Standing (continuously); ☐ Up to 30 min ☐ Up to 1 hour ☐ No restriction ☐ Other: _____ _____	Sitting (continuously); ☐ Up to 30 min ☐ Up to 1 hour ☐ No restriction ☐ Other: _____ _____	Lifting Floor to Waist; ☐ Up to 20 lbs ☐ Up to 30 lbs ☐ Up to 40 lbs ☐ No restriction ☐ Other: _____ _____
Lifting Waist to Shoulder; ☐ Up to 20 lbs ☐ Up to 30 lbs ☐ Up to 40 lbs ☐ No restriction ☐ Other: _____ _____	Pushing; ☐ Up to 10 lbs ☐ Up to 20 lbs ☐ Up to 30 lbs ☐ No restriction ☐ Other: _____ _____	Pulling; ☐ Up to 10 lbs ☐ Up to 20 lbs ☐ Up to 30 lbs ☐ No restriction ☐ Other: _____ _____	Stair Climbing; ☐ Unable ☐ 2-3 steps only ☐ Own pace ☐ Assisted ☐ No restriction
Ability to Use **Left** Hand; ☐ Hold objects _____ ☐ Grip _____ ☐ Type _____ ☐ Write _____ ☐ No Restriction	Ability to Use **Right** Hand; ☐ Hold objects _____ ☐ Grip _____ ☐ Type _____ ☐ Write _____ ☐ No Restriction	Employee is; ☐ Left handed ☐ Right handed ☐ Ambidextrous	Travel to Work; *Public Transit:* ☐ Yes ☐ No *Drive a car:* ☐ Yes ☐ No

COGNITIVE ABILITIES

Self-Supervision/autonomy; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____	Deadline Pressures; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____	Attention to Detail; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____	Time Management; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____
Exposure to Confrontation; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____	Working in isolation; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____	Attention/sustained focus; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____	Memory; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____
Planning; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____	Organization; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____	Reasoning; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____	Problem Solving; ☐ Unable to perform ☐ Limited capacity ☐ No restriction Specify task; _____
Calculation; ☐ Unable to perform ☐ Limited capacity ☐ No restriction	Working in Cooperation with Others; ☐ Unable to perform ☐ Limited capacity ☐ No restriction	Multitasking; ☐ Unable to perform ☐ Limited capacity ☐ No restriction	Working under specific instruction; ☐ Unable to perform ☐ Limited capacity ☐ No restriction

Hours Per Day: ☐ 4 Hours; ☐ 8 Hours; ☐ 12 Hours; ☐ On-Call Shifts; ☐ No restriction

Additional Comments: _____

_____

D. Health Professional's Information

Designation; ☐ Physician; ☐ Chiropractor; ☐ Physiotherapist; ☐ Other_____

_____	_____	_____
Health Professional's Name (please print)	Health Professional's Signature	Date
_____	_____	
Telephone	Fax	

I hereby declare that the information being submitted in Sections B and C on this form is true and complete. It is an offense to knowingly make a false or misleading statement.