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**Fitness to Work and Functional Abilities Assessment Form**

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| **SECTION A – Employee information** | | (To be completed by the manager) | |
| **Name of employee** | **Branch/Division** | | **Office/Location** |
|
| **Job title** | **Regular work schedule**  \_\_\_\_\_\_ hours/day  \_\_\_\_\_\_ days/week | | **Absence commenced date**  Summary of absences attached |
| **Employment Status** |
| **Name of Manager / Supervisor** | **Signature** | | **Date** (dd-mm-yyyy) |
| **A letter containing further information has been joined to this form  yes  no** | | | |

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| **SECTION B – Fitness to work** | (To be completed by health care practitioner) |
| **Does the employee have a health condition (disability\*) that must be accommodated in the workplace?** | |
| Yes  No | |
| \* According to the Canadian Human Rights Act, “disability” means “any previous or existing mental or physical disability and includes disfigurement and previous or existing dependence on alcohol or a drug. | |
| **Which of these statements applies to the employee’s situation?**  Fit to work (able to work his or her regular work schedule without limitation or restriction) – **Complete Sections C and F**    Fit to work **subject** to certain functional limitations or restrictions – **Complete Sections C, D, E and F**  Date of next appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (dd-mm-yyyy)    Unfit to work – **Complete Section F**    Date of next appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (dd-mm-yyyy)  **Note: Do not provide medical diagnosis, treatment or medication information.** | |

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| **SECTION C – Work schedule** | | | | | | (To be completed by health care practitioner) | | | | | |
| **Is the employee fit to work his or her regular work schedule as specified in Section A?** | | | | | | | | | | | |
| Yes  No Expected return-to-work date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (dd-mm-yyyy) | | | | | | | | | | | |
| **If the employee is unable to work the regular schedule**, please indicate in the table below the amount of hours per day and the numbers of days per week that the employee is able to work. Please specify the information for a 12 week period. | | | | | | | | | | | |
| **Week**  **1** | **Week**  **2** | **Week**  **3** | **Week**  **4** | **Week**  **5** | **Week**  **6** | **Week**  **7** | **Week**  **8** | **Week**  **9** | **Week**  **10** | **Week**  **11** | **Week**  **12** |
| **Hrs./Day** | **Hrs./Day** | **Hrs./Day** | **Hrs./Day** | **Hrs./Day** | **Hrs./Day** | **Hrs./Day** | **Hrs./Day** | **Hrs./Day** | **Hrs./Day** | **Hrs./Day** | **Hrs./Day** |
| **Days/Wk.** | **Days/Wk.** | **Days/Wk.** | **Days/Wk.** | **Days/Wk.** | **Days/Wk.** | **Days/Wk.** | **Days/Wk.** | **Days/Wk.** | **Days/Wk.** | **Days/Wk.** | **Days/Wk.** |

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| **SECTION D – Abilities required to perform principal work duties** | | | | |
| **To be completed by the manager**  (If required, use Section E to provide more details) | | | **To be completed by health care practitioner**  (If required, use Section E to provide more details) | |
| The employee’s principal work duties require the following physical and/or non-physical capacities: | | | Please provide details on each of the limitations and restrictions. | |
| **Movement of the spinal column** | | | **Limitations and restrictions**  None  Permanent  Temporary  Anticipated duration:\_\_\_\_\_\_\_\_\_ |  |
| Back: | Bending forward  Bending backward  Side bending  Twisting | |
| Neck: | Bending forward  Looking up  Side bending  Rotation | |
| **Sitting activities**  Computer work: \_\_\_\_% of day  Meetings: \_\_\_\_% of day  Desk work (reading, writing): \_\_\_\_ % of day  Driving: \_\_\_\_% of day  Telephone use ( with headset): \_\_\_\_ % of day | | | **Limitations and restrictions**  None  Permanent  Temporary  Anticipated duration:\_\_\_\_\_\_\_\_\_ |  |
| **Standing activities**  Standing: \_\_\_\_% of day  On what type of surface: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Walking: \_\_\_\_\_ km, or \_\_\_\_\_ hours per day  On what type of surface: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Stooping  Crouching/Squatting  Kneeling  Operating general office equipment (e.g., printer)  Activities requiring balancing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Climbing (e.g., stairs, stepladder): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | **Limitations and restrictions**  None  Permanent  Temporary  Anticipated duration:\_\_\_\_\_\_\_\_\_ |  |
| **Lifting, carrying, pushing or pulling** | | | **Limitations and restrictions**  None  Permanent  Temporary  Anticipated duration:\_\_\_\_\_\_\_\_\_ |  |
| Lifting from floor to waist  Lifting from waist to shoulder  Lifting above shoulder  Carrying  Pushing/pulling | | Max. weight:\_\_\_\_ (kg)  Max. weight:\_\_\_\_ (kg)  Max. weight:\_\_\_\_ (kg)  Max. weight:\_\_\_\_ (kg)  Max. weight:\_\_\_\_ (kg) |
| **Working with shoulders, elbows, wrists,**  **hands or fingers**  Reaching:  Above shoulder level  Below shoulder level  At shoulder level  Using a keyboard: \_\_\_\_\_% of day  Writing: \_\_\_\_% of day  Using computer mouse  Filing  Handling objects  Handling vibrating tools/objects  Handling tools requiring strong hand grip | | | **Limitations and restrictions**  None  Permanent  Temporary  Anticipated duration:\_\_\_\_\_\_\_\_\_ |  |

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| **SECTION D – Abilities required to perform principal work duties** | | |
| **To be completed by the manager**  (If required, use Section E to provide more details) | **To be completed by health care practitioner**  (If required, use Section E to provide more details) | |
| The employee’s principal work duties require the following physical and/or non-physical capacities: | Please provide details on each of the limitations and restrictions requiring accommodation measures. | |
| **Activities requiring senses**  Speaking  Hearing  Near vision  Far vision  Depth perception  Viewing computer screen -\_\_\_\_% of day  Driving | **Limitations and restrictions**  None  Permanent  Temporary  Anticipated duration:\_\_\_\_\_\_\_\_\_ |  |
| **Cognitive/mental demands:**  Attention to detail  Continuous alertness, sustained concentration/focus  Multitasking  Communicate effectively  Autonomy / Minimal supervision  Working under specific instructions  Achieving specific performance standards  Retention of information  Initiative  Adaptability  Problem solving, decision making  Analytical thinking  Sound judgement | **Limitations and restrictions**  None  Permanent  Temporary  Anticipated duration:\_\_\_\_\_\_\_\_\_ |  |
| **Social/emotional demands:**  Working in isolation  Teamwork  Supervising others  Relationship/network building  Influencing others  Conflict resolution  Seeking/responding to feedback  Exposure to emotional or confrontational situations  Working closely with the public, clients or others  Working in crisis or emergency situations | **Limitations and restrictions**  None  Permanent  Temporary  Anticipated duration:\_\_\_\_\_\_\_\_\_ |  |
| **Schedule demands:**  Following a schedule, maintaining attendance/punctuality  Overtime work  Shift work  On call  Repetitive work  Variety of tasks  Travel:  Frequency per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Mode of transportation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Time of day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Limitations and restrictions**  None  Permanent  Temporary  Anticipated duration:\_\_\_\_\_\_\_\_\_ |  |

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| **SECTION E – Specific questions, issues/comments** |
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| **SECTION F – Signature of health care practitioner** | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name (please print) | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature | |  | | --- | | Stamp of health care practitioner | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date (dd-mm-yyyy) |