District of Nipissing Social Services Administration Board

Conseil d'administration des services sociaux du district de Nipissing

Medical Ability to Work Form
(excess of 5 days)

The purpose of this form is to provide the patient with the necessary information that they need to give to their employer to help the employer make decisions about accommodating the patient, providing disability leave, or assessing if the patient can return to work.

TO BE COMPLETED BY EMPLOYEE

Employee's Name_____ Phone No._____

Address_____|_____|_____|_____|__|__|__|__|__|__
(Street Number and Name) (Apt. No.) (City/Town) (Province) (Postal Code)

Date of Birth: _____ _____ _____
Day Month Year

NOTES TO PHYSICIAN

When completing this form, disclose only information necessary to meet the purpose of the form. It is <u>not</u> necessary to provide a diagnosis or treatment information.

1. This form is not intended for WSIB purposes. For a work-related injury or illness, the required WSIB forms must be completed.
2. This form does not replace forms related to an employee's ability to work that are required by:
   - WSIB
   - third-party insurers, or
   - employer-funded medical benefit plan
3. Where choices are indicated below, please mark your selection.
4. Please sign and date page 2, and keep a copy of this form.

SECTION A: ILLNESS / INJURY INFORMATION

Date illness/injury began: _____ Date of examination by Physician: _____

Have you scheduled a follow up appointment ☐ Yes ☐ No If yes, when? _____

Has a treatment plan been prescribed to the patient? ☐ Yes ☐ No If no, please explain why. _____

_____

_____

This patient is medically able to work **<u>without</u>** limitations or restrictions as of _____
Date

This patient is medically able to work **<u>with</u>** limitations or restrictions as of _____
Date

Anticipated length of illness: ☐ _____ days ☐ 2 to 4 weeks ☐ 4 to 6 weeks ☐ 6 weeks to 3 months ☐ more than 3 months

Please describe the employee's current limitations or restrictions, if applicable (please use the capabilities section set out in Section B, if applicable)

_____

_____

_____

Expected length of time modifications will be required: _____

_____

_____

SECTION B: CAPABILITIES INFORMATION

<u>FUNCTIONAL ABILITIES</u>:

Walking (continuously): ☐ up to 20 min; ☐ up to 1 hour; ☐ no restriction; ☐ Other (e.g. uneven ground) _____

Standing (continuously): ☐ up to 20 min; ☐ up to 1 hour; ☐ no restriction; ☐ Other _____

Sitting (continuously): ☐ up to 30 min; ☐ up to 1 hour; ☐ no restriction; ☐ Other _____

Stair climbing: ☐ unable ☐ 2 – 3 steps only; ☐ own pace ☐ assisted ☐ no restriction

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 _____

Note: Completion of this form is an uninsured medical service. There may be a fee to the patient for completion of this form. Employee will be reimbursed in accordance with Article 19.01 of the Collective Agreement.

Carrying ☐ up to 20 lbs; ☐ up to 30 lbs ☐ up to 40 lbs; ☐ no restriction; ☐ Other_____

Reaching (please specify) _____ ☐ no restriction; ☐ Other _____

Bending – repetitive (please specify) _____ ☐ no restriction; ☐ Other _____

Twisting – repetitive (please specify) _____ ☐ no restriction; ☐ Other _____

Employee is: ☐ Left handed ☐ Right handed ☐ Ambidextrous

Limited ability to used **left** hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ write

Limited ability to used **right** hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ write

Completely unable to use **left** hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ write

Completely unable to use **right** hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ write

Hours per day: ☐ 4 hours ☐ 6 hours ☐ 8 hours ☐ no restriction ☐ less then 4 hours (specify) _____

COGNITIVE ABILITIES:

Concentration	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Attention	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Memory	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Organization/Planning	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Deadline Pressures	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Time Management	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Attention to Detail	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Multi-tasking	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Responsibility/Accountability	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Problem Solving	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Exposure to Confrontation	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Interpersonal Contact	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____

ENVIRONMENTAL STIMULI:

Exposure to heat/cold	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Exposure to dust/fumes/odour	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____
Exposure to chemicals	☐ limited capacity	☐unable to perform	☐ no restriction;	☐ Other _____

☐ Other (please specify) _____

_____

_____

_____

Additional Comments/Accommodations Required:

_____

_____

_____

_____

SECTION C: ATTENDING PHYSICIAN'S INFORMATION

Physician's name (please print): _____ Speciality:_____

Address:_____

Telephone: _____ Fax:_____

Signature: _____ Date: _____

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