Government of Saskatchewan

# Stay At or Return to Work Form 111

Last revised: October 2018
Last reviewed: October 2018
**Next review: October 2019**

*The purpose of this form is to provide information to assist the employee to stay at work if possible, or plan for the employee's safe return to work at the earliest possible date.*

## Section I: Personal Information (To be completed by the Manager/Supervisor)

Employee's Name _____ Employee's Work Location _____

Employee's Occupation _____

Work-related injury or illness? ❑ Yes ❑ No Date of injury or illness or date became aware: _____

* *Supervisor to complete WCB E1 Form and Incident Reporting & Investigation Form 101 if this illness/injury is workplace related.*

Brief Description of Employee's Regular Core Duties (Attach Job Demands as appropriate):

Employee to return this form (completed both sides) to Manager/Supervisor within ___ days.

Printed Name of Manager/Supervisor completing this form. _____

## Section II: Employment Responsibilities (To be completed by Manager/Supervisor and signed by employee)

1) Take this form to your Licensed Health Care Practitioner regarding this injury/illness/surgery so he/she can complete Section III (reverse side) and return it to you during that visit.
2) You are to return this form (completed both sides) to your Manager/Supervisor within_____days (as above)
3) Alternate contact information: (If person to receive the form different from Manager/Supervisor e.g. Ministry Contact, Human Resources, etc.). Manager/Supervisor to fill in.

   Name and Title: _____
   Address: _____
   Email and Phone: _____
   Fax: _____

4) If this is a workplace illness/injury, you will also complete a WCB W1 Form and assist in the completion of an Incident Reporting and Investigation Form 101.
5) I acknowledge my responsibilities and CONSENT my Licensed Health Care Practitioner to completing Section III of this form.

_____ _____
Employee Signature Date

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## Section III: To be completed by the licensed health care practitioner

_____
**Date of Examination**

Do your findings restrict this employee from attending work and any and all duties? ❑ Yes ❑ No
If yes, please indicate **ALL** the restrictions /limitations. Check **ALL** restrictions that apply and specify details in the space provided below.

☐ Lifting: ○ <10lbs ○ <20lbs ○ <50lbs ○ Avoid repetitive lifting
○ Avoid overhead lifting ○ Lifting as tolerated ○ No lifting

☐ Bending /twisting: ○ No bending /twisting ○ Avoid repetitive bending/twisting

☐ Standing ☐ Climbing (stairs /ladder) ☐ Walking ☐ Kneeling / Crouching

☐ Keyboarding ☐ Pushing/Pulling ☐ Sitting

☐ Limitations due to environment ○ Heat ○ Cold ○ Dust ○ Fumes

☐ Operating Equipment ☐ Driving

☐ Cognitive limitations ○ Memory ○ Concentration ○ Decision making ○ Multi-tasking

☐ Other _____

Anticipated duration of restriction(s)_____days. If more than one restriction, indicate the duration of each:

_____

Date of re-evaluation/next visit with you (if necessary): _____

Please provide further details or additional information that may restrict the employee's plan to safely stay at or return to the workplace (if applicable): **Do not include diagnosis**

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|---|
| |

_____
Signature of Licensed Health Care Practitioner

*Licensed Health Care Providers Stamp*