

APPENDIX B – ABILITIES FORM

Employee Group:	Requested By:
WSIB Claim: <input type="checkbox"/> Yes <input type="checkbox"/> No	WSIB Claim Number:

To the Employee: The purpose for this form is to provide the Board with information to assess whether you are able to perform the essential duties of your position, and understand your restrictions and/or limitations to assess workplace accommodation if necessary.

Employee's Consent: I authorize the Health Professional involved with my treatment to provide to my employer this form when complete. This form contains information about any medical limitations/restrictions affecting my ability to return to work or perform my assigned duties.

Employee Name: <i>(Please print)</i>	Employee Signature:
Employee ID:	Telephone No:
Employee Address:	Work Location:

1. Health Care Professional: The following information should be completed by the Health Care Professional

Please check one:

Patient is capable of returning to work with no restrictions.

Patient is capable of returning to work with restrictions. Complete section 2 (A & B) & 3

I have reviewed sections 2 (A & B) and have determined that the Patient is totally disabled and is unable to return to work at this time. Complete sections 3 and 4. Should the absence continue, updated medical information will next be requested after the date of the follow up appointment indicated in section 4.

First Day of Absence: _____	General Nature of Illness <i>(please do not include diagnosis)</i>: _____
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Date of Assessment:
dd mm yyyy

2A. Health Care Professional to complete. Please outline your patient's abilities and/or restrictions based on your objective medical findings.

PHYSICAL (if applicable)											
Walking: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 100 metres <input type="checkbox"/> 100 - 200 metres <input type="checkbox"/> Other <i>(please specify)</i> :	Standing: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15 - 30 minutes <input type="checkbox"/> Other <i>(please specify)</i> :	Sitting: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 minutes - 1 hour <input type="checkbox"/> Other <i>(please specify)</i> :	Lifting from floor to waist: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other <i>(please specify)</i> :								
Lifting from Waist to Shoulder: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other <i>(please specify)</i> :	Stair Climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 steps <input type="checkbox"/> 6 - 12 steps <input type="checkbox"/> Other <i>(please specify)</i> :	Use of hand(s): <table style="width:100%; border:none;"> <tr> <td style="width:50%; border:none;">Left Hand</td> <td style="width:50%; border:none;">Right Hand</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Gripping</td> <td style="border:none;"><input type="checkbox"/> Gripping</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Pinching</td> <td style="border:none;"><input type="checkbox"/> Pinching</td> </tr> <tr> <td style="border:none;"><input type="checkbox"/> Other <i>(please specify)</i>:</td> <td style="border:none;"><input type="checkbox"/> Other <i>(please specify)</i>:</td> </tr> </table>		Left Hand	Right Hand	<input type="checkbox"/> Gripping	<input type="checkbox"/> Gripping	<input type="checkbox"/> Pinching	<input type="checkbox"/> Pinching	<input type="checkbox"/> Other <i>(please specify)</i> :	<input type="checkbox"/> Other <i>(please specify)</i> :
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