APPENDIX B - ABILITIES FORM

Employee Group:	***Requested By:***
WSIB Claim : **Yes ☐ 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: *(Please print)*	**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 & 8) & 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 ***(please do not include diagnosis):***

Date of assessment :

dd mm yyyy

110, avenue Drewry, Toronto ON M2M 1C8
T 416 397-6564 | 1 800 274-3764 F 416-397-6576
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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: ☐ Full Abilities ☐ Up to 100 metres ☐ 100 - 200 metres ☐ Other *(please specify):*	**Standing:** ☐ Full Abilities ☐ Up to 15 minutes ☐ 15 - 30 minutes ☐ Other *(please specify):*	**Sitting:** ☐ Full Abilities ☐ Up to 30 minutes ☐ 30 minutes - 1 hour ☐ 0ther *(please specify):*	**Lifting from floor to waist:** ☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 - 10 kilograms ☐ Other *(please specify):*
Lifting from Waist to Shoulder: ☐ Full abilities ☐ Up to 5 kilograms ☐ 5 - 10 kilograms ☐ Other *(please specify):*	**Stair Climbing:** ☐ Full abilities ☐ Up to 5 steps ☐ 6 -12 steps ☐Other *(please specify):*	**Use of hand(s):** **Left Hand** ☐Gripping ☐ Pinching ☐ 0ther *(please specify):*	**Right Hand** ☐ Gripping ☐ Pinching ☐ 0ther *(please specify):*
☐ **Bending/twisting** repetitive movement of	☐ **Work at or above shoulder activity:**	☐ **Chemical exposure to:**	**Travel to Work:** Ability to use public transit: ☐Yes ☐No Ability to drive car : ☐Yes ☐No

2B : COGNITIVE : (please complete all that is applicable)

Attention and Concentration: ☐ Full Abilities ☐ Limited Abilities ☐Comments::	**Following Directions:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Decision-Making/Supervision:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Multi-Tasking:** ☐ Full Abilities ☐ Limited Abilities ☐Comments:
Ability to Organize: ☐ Full Abilities ☐Limited Abilities ☐ Comments:	**Memory:** ☐Full Abilities ☐ Limited Abilities ☐ Comments	**Social Interaction:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Communication:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:

Please identify the assessment tool(s) used to determine the above abilities *(Examples: Lifting tests, grip strength tests, Anxiety Inventories, Self-Reporting, etc*

Additional comments on **Limitations (notable to do) and/or Restrictions (should/must not do) for all medical conditions:**

3: Health Care Professional to complete.

From the date of this assessment, the above will apply for approximately: ☐ 6 - 10 days ☐ 11 - 15 days ☐ 16 - 25 days ☐ 26 days +	Have you discussed return to work with your pattient? ☐Yes ☐ No
Recommendations for work hours and start date (if applicable): ☐ Regular full time hours ☐ Modified hours ☐ Graduated hours (please give details)	Start date : _____ dd /mm/ yyyy

Is your patient on a treatment plan? ☐ Yes ☐ No

Has a referral to another Health Care Professionnal been made? ☐ Yes ☐ No

If a referral has been made, will you continue to be the patient's primary Health Care Provider? ☐ Yes ☐ No

Yes (optional – please specify) :_____

4: Recommended date of next appointment to review Abilities and/or Restrictions :

_____
dd /mm/yyyy

Completing Health Care Professional Name: (Please Print)	
Date:	
Telephone Number :	
Fax Number :	
Signature:	