Yellowknife Education District No. 1.

Return to Work Program

March, 2011

Yellowknife Education District No. 1.

INDEX

Policy Commitment Statement

Yellowknife Education District No. 1 (YK1) is committed to preventing workplace injuries and illnesses. In the event an employee is injured or ill due to a workplace incident, YK1 is committed to ensuring their successful transition back to work through a Return-to-Work (RTW) program.

If employees are unable to perform their regular full duties as a result of an illness or injury, we:

- take all reasonable steps to return the employee to their pre-injury/illness position in a timely manner; and
- return the employee to suitable work which is safe and consistent with their functional abilities, if they are unable to return to their pre-injury/illness position.

Employee and employer RTW roles and responsibilities are as follows:

Employees will:

- contact employer as soon as possible after the injury or illness occurs, and maintain communication;
- assist with identifying suitable and available employment;
- accept suitable employment when identified;
- provide updates on medical status and progress throughout recovery period;
- inform healthcare provider of available suitable work when identified; and
- provide any appropriate information requested to the employer and the
- Workers' Safety and Compensation Commission during the return to work process.

The employer will:

- contact employee as soon as possible after the injury or illness occurs, and maintain communication;
- provide suitable and available employment;
- stay in touch with employee throughout the recovery period; and
- provide the Workers' Safety and Compensation Commission with any appropriate information requested concerning the employee's return to work.

YK1 will develop individualized RTW plans for injured/ill employees which include processes for RTW recovery and ensure regular communication between employees and the employer. Communication can be in the form of in-person meetings, via telephone conversations, by emails, or written correspondence.

YK1 is committed to ensuring the success of their safe RTW program.

Letter of Understanding

Between
Yellowknife Education District No.1
and
The Northwest Territories Teachers' Association

Purpose: Return to Work Program

We believe that a workplace-based joint management/union approach, which will assist employees who become injured or ill to return to work, is the most effective strategy toward reducing the economic cost of disability and maintaining the employability of our employees.

We believe that this program can be implemented and be compatible with current statutory and collective agreement obligations.

Both parties agree to develop and implement an effective Joint Management / Union Return to Work Program which will return workers back to a productive capacity.

The Joint Health and Safety Committee will be the forum for discussing and implementing details of this program.

_____	_____	_____
Yellowknife Education District No.1	NWTTA	Date

*At the date of policy approval, the NWTTA had not signed the Letter of Understanding.

Letter of Understanding

Between
Yellowknife Education District No.1
and
The United Steeworkers (Local 8646)

Purpose: Return to Work Program

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The Joint Health and Safety Committee will be the forum for discussing and implementing details of this program.

Yellowknife Education District No.1	USW (Local 8646)	May 16 2011 Date

Program Objectives

Expected Outcomes

- increased awareness of disability issues for all employees
- reduction in days lost due to absences from injuries and illnesses
- fair and consistent process for employees returning to work
- compliance with current and future legislative obligations
- reduce workplace safety and insurance costs

Return to Work Program
Implementation Plan

1) Assign responsibility for the program.

2) Write “Roles and Responsibilities” and communicate it to all employees.

3) Meet regularly to manage Return to Work Program.

4) Evaluate Program Objectives quarterly / annually.

Return to Work Plan
Statement of Eligibility and Exit Criteria

Eligibility Criteria into RTW Process

Employees who have injuries or illnesses resulting from the workplace.
(This may include employees who have illnesses or injuries resulting from outside of the workplace.)

The RTW process begins immediately after the injury or illness occurs.

Exit Criteria from the RTW Process

- Return to regular job at full capacity.
- Return to full functional capacity supported by functional ability information.
- Unable to identify suitable, available work.
- Permanent placement in alternative work.

Return to Work Plan
Process Procedures

Employee

- Immediately report all accidents and illnesses and obtain necessary first aid and/or health care. If the accident or illness is work-related, it is the employee's responsibility to file a WSCC Claim - Worker's Report of Injury (see Appendix A) and to provide a copy of the Injury Report to his/her supervisor, so that he/she can complete the WSCC – Employer's Report of Injury (see Appendix B)
- Sign Medical Release & Functional Capabilities Form to consent to disclosure of functional abilities (FA) information, obtain Functional Abilities Timely Return to Work (see Appendix C) form from company and take to Health Care Practitioner to complete. Return completed functional abilities form to Yellowknife Education District No.1.
- Assist Yellowknife Education District No.1 to identify suitable work consistent with their functional abilities.
- Accept suitable employment when identified.
- Provide updates on medical status and progress throughout recovery period.
- Inform healthcare provider of available suitable work when identified
- Co-operate in their RTW and provide appropriate information requested to the Yellowknife Education District No.1 and WSCC during the return to work process.

Employer

- Complete the WSCC - Employer's Report of Injury within 3 days of learning of a reported accident in the workplace. This should be completed by the employee's supervisor, faxed to WSCC and a copy should be sent to personnel to be placed on the employee's file.
- Contact the employee as soon as possible after the injury or illness occurs, and maintain communication.
- Review completed Functional Abilities form with employee to identify suitable work.
- Write an RTW Plan in co-operation with the employee and monitor the plan.
- Communicate with employee regularly throughout recovery period.
- Provide the Workers' Safety and Compensation Commission with any appropriate information requested concerning the employee's return to work

Assignment of Other Roles & Responsibilities:

Return to Work Coordinator: the role of the RTW Coordinator has been assigned to the Manager, Human Resources.

Return to Work Committee: committee members will be vetted through the Occupational Health & Safety Committee. The make-up of the committee will depend on the employee that is being assisted in Returning to Work. (A union representative, the supervisor, an OHSC member, a member of the Sr. Management Team and the RTW Coordinator will make up each committee).

Return to Work Plan
Dispute Resolution Mechanism

Whenever there is a dispute between Yellowknife Education District No.1 and the employee the following steps will be taken:

1. Review the RTW Plan, where an error has been made, reasonable steps will be taken by Yellowknife Education District No.1 to correct the error.

2. If the dispute is regarding functional ability / suitability of work match:
   a) Obtain an updated Functional Abilities Timely Return to Work form, and review the suitability of available work.
   b) If necessary, where the recovery is not progressing as anticipated, refer the employee to a Health Care Practitioner paid for by Yellowknife Education District No.1 to conduct a more comprehensive functional abilities evaluation.

3. Where the dispute cannot be resolved, refer the matter to the WSCC for assistance from a RTW Mediator for determination of the dispute.

Develop Individual Return to Work Plans

A return to work play lays out the steps that need to be taken to return an employee to his or her pre-injury job.

In the idea situation, the plan is developed jointly by the injured employee, the employee's supervisor, and if applicable, the return to work program manager (who co-ordinates the process), the worker's health care provide (through provision of restrictions) , and the union representative, (if applicable). Supervisors from other areas or staff from the WSCC can assist in the process when the need arises. A return to work plan includes the following:

- **The goals of the plan**.
  These goals set out milestones for the worker to achieve until he or she reaches the final goal: a return to pre-injury employment.

- **The actions required to achieve these goals**.
  This includes the responsibilities of the worker, the supervisor, or manager, and any co-workers who will be assisting the worker.

- **Time frames for achieving these goals.**
  These will provide a yardstick to measure the employee's progress. It is important that the plan has a beginning and an end, as graduated work is a means to achieve a return to pre-injury work, and is not an end in itself. Make sure to include a clear definition of what is considered progress (e.g., the employee can work five hours a day by week three, or the worker can assume tasks by week five).

- **Health care needs.**
  If, for example, the worker is going to attend health or medical appointments during working hours, these visits must be coordinated with the requirements of the proposed return to work plan. Staff that will be impacted by these health care needs will also need to be advised (with the worker's permission).

The following pages contain examples of the kinds of formats you can develop for your return to work plan.

SAMPLE #1

Return to Work Plan

RETURN TO WORK PLAN		
NAME:	DATE:	
Goal: Return to regular duties	START DATE:	
	COMPLETION DATE:	
Limitations:		
Accommodation(s):		
Hours of work:		
Location of work:		
Supervisor:		
DATE	DUTIES	FOLLOW-UP

Employee Signature: _____

Print Name: _____

Employer Signature: _____

Print Name: _____

Sample #2

Return to Work Plan

Developed: *(date)*

Revised: *(date)*

The following Return to Work Plan is in effect starting *(date) .* Any deviation to the plan must be approved by RTW Coordinator and supported with medical documentation.

The parties agree to the following Return to Work Plan for *(employee name).*

Current Medical or Functional Restrictions / Limitations

Duration – *(# of weeks or months)*

Date	Return to Work
	Graduated Hours (1st week)
	Graduated Hours (2nd week)
	Graduated Hours (3rd week) etc.
	Other Restrictions & Limitations:

Temporary Modified Job:

From Date to Date:

List modified job duties.

Scheduled Plan Reviews:

Date:

Scheduled Plan Completion:

Date:

_____ _____

Signature: RTW Coordinator **Date**

I have reviewed this letter, understand and agree to the terms as laid out. I will not work in excess of these restrictions and understand that any changes to this plan must be approved prior to implementation:

_____ _____

Signature: Employee **Date**

Appendix A
Worker's Report of Incident CS001 1004.pdf

Appendix B
WCB Employers Report of Accident.pdf

Appendix C
Functional Abilities Form -yk1.pdf

WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

EMPLOYER'S REPORT OF ACCIDENT

If a worker is injured at work, you need to complete this form so that the claim can proceed.

Employer Information

1. Business Name		Email Address
2. Address	Community	Postal Code
3. Telephone (include area code)	4. Worker's Supervisor's Name?	

Worker Information

5. Last Name	6. First Name	
7. Mailing Address	Community	Postal Code
8. Residential Address	9. Date of Birth YY MM DD	10. ❑ Male ❑ Female
11. Telephone (include area code)	12. Social Insurance Number	13. ❑ Single ❑ Married ❑ Common-law ❑ Widowed ❑ Divorced

14. Number of Dependants	15. Worker's Occupation	16. Is a job description available? ❑ Yes ❑ No

17. What province or territory was the worker hired in?

18. Is the worker a subcontractor? ❑ Yes ❑ No 19. Is the worker an owner or operator? ❑ Yes ❑ No

Accident Details

20. Place of Accident – Name of City/Town, Province/Territory

21. Was the worker on the employer's premises when the accident occurred? ❑ Yes ❑ No

22. Accident Date Y/ M/ D/ Time AM / PM	23. Date first reported to employer Y/ M/ D/ Time AM / PM
24. Date first disabled from work? Y/ M/ D/ Time AM / PM	25. Time worker commenced work on the day of the accident? Time AM / PM

26. Does the worker have a job to return to? If no, explain. ❑ Yes ❑ No

27. Was first aid rendered? ❑ Yes ❑ No If yes, when?
By whom?

28. Name and address of attending Health Care Professional

Complete All Questions Below – (Give Full Explanation – attach extra sheets if necessary)

29. Were the worker's actions at the time of injury for the purpose of your business? ❑ Yes ❑ No

30. Is the activity part of the worker's regular work? ❑ Yes ❑ No If yes explain	31. Are you satisfied the incident occurred as reported? ❑ Yes ❑ No If yes explain

32. Please describe the accident in as much detail as possible. Include where it took place, what the worker was doing at the time of injury, what equipment was being used, and whether gas, chemicals or extreme temperatures were involved. Was language a contributing factor? (attach sheet if necessary)

33. What part of the worker's body was injured? (left/right side, hand, eye, back, etc.)
What type of injury did they experience? (sprain, bruise, etc.)

34. Was anyone not employed by you involved in the accident? ❑ Yes ❑ No If yes, explain.

35. Was the worker disabled longer than the date of the accident? ❑ Yes ❑ No

36. If no time loss, is the worker performing modified duties? If yes, provide list of duties.

37. Is light duty available? ❑ Yes ❑ No If yes, when? YY MM DD

38. Has the worker been advised of light duties? ❑ Yes ❑ No If yes, when? YY MM DD

39. Please supply a list of duties available. (attach sheet if necessary)

IF THE WORKER WAS DISABLED LONGER THAN THE DATE OF THE ACCIDENT, PLEASE CONTINUE. IF NOT, PLEASE SIGN AT THE BOTTOM OF THE NEXT PAGE.

Worker's Full Name:	WCB Claim Number:

Complete All Questions Below –
Give Full Explanation – attach extra sheets if necessary

40. Has the worker returned to work? ❑ Yes ❑ No If yes, when? | YY | MM | DD |

41. Will you pay the worker for the period of disability? ❑ Yes ❑ No
If yes, for how long? (e.g. 1 month, 6 months, etc.)
Will you continue to pay the employee benefits while the worker is receiving compensation payments? (e.g. travel, Northern living allowance) ❑ Yes ❑ No If yes please explain

42. Worker's type of employment ❑ permanent ❑ seasonal ❑ casual ❑ summer student ❑ apprentice ❑ part-time

43. Is the job subject to seasonal layoffs ❑ Yes ❑ No
or lack of work layoffs ❑ Yes ❑ No

Wage Information – please complete

44. Date of hire | YY | MM | DD | 47. If non-permanent, what is the expected end date of employment? | YY | MM | DD |

45. Usual hours and days in work week Days off ____________
____________ hours ____________ days from ____________ AM / PM to ____________ AM / PM
e.g. 40 hrs/week hours 5 days from 8 AM / PM to 5 AM / PM

46. If worker works an irregular work week (shifts, turnarounds, etc.), please supply one complete shift cycle
Date shift cycle started ____________ Number of days on ____________ Number of days off ____________

Circle days on:

M T W T F S S M T W T F S S M T W T F S S M T W T F S S M T W T F S S M T W T F S S

47. What is the hourly rate of pay? ________ /hr
How often is the worker paid? ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Other – please explain

48. Specify amount of time off for lunch Is worker paid for the time? ❑ Yes ❑ No

49. Does the worker receive any other benefits? ❑ Yes If yes, explain and give amounts.
i.e. (vacation pay, settlement allowance, etc.) ❑ No

50. Does the worker regularly work overtime ❑ Yes ❑ No?

51. Provide an estimate of regular overtime hours (weekly / monthly / yearly) ____________
At what rate? ❑ Double-time ❑ Time and a half ❑ Other ____________

52. Give worker's exact gross earnings for the 12 months prior to date of accident

IMPORTANT:

NOTIFICATION OF ACCIDENT MUST REACH THE WORKERS' COMPENSATION BOARD OFFICE WITHIN THREE WORKING DAYS OF ACCIDENT. IT IS RECOMMENDED THAT THIS FORM BE FAXED IN THE NORTHWEST TERRITORIES TO 1-866-277-3677 OR IN NUNAVUT AT 1-867-979-8501.

Completed by (please print)		Signed at (city, town, village)
Authorized Signature	Phone Number	Date

If you would like assistance filling in this form, or for more information, please contact one of our offices, listed below, or go to our website: www.wcb.nt.ca or www.wcbnunavut.ca

"... An employer who fails to submit completed accident reports on a timely basis is liable to penalties as follow:

- $250 for each occurrence for the first 2 occurances.
- $500 for the next 2 occurances
- $1,000 for each additional occurrence.

Decisions not to apply the late reporting penalty must be approved by the NWT or Nunavut Manager of Claimant Services.

Where the employer fails to submit accident reports as required or requested by the Board, the Board may make a special investigation of the facts and circumstances surrounding an injury and charge the cost of the investigation to the employer (per Policy 11.02 '*Reporting an Accident*', WCB of the Northwest Territories and Nunavut Policy Manual)."

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax 1-866-277-3677
or
❑ Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8501
❑ Box 368 • Rankin Inlet, NU X0C 0G0 • Telephone: (867) 645-5600 • Fax: (867) 645-5601
❑ Box 1188 • Inuvik, NT X0E 0T0 • Telephone: (867) 678-2301 • Fax: (867) 678-2302

Ce formulaire est disponible en français.
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WSCC Workers' Safety & Compensation Commission | ᐃᖃᓗᓇᐃᖅᑎᑐᓂ ᐊᑦᑕᓇᖅᑐᓄᑦ ᐊᒻᒪᓗ ᓇᓕᓕᒫᓂᖅ ᖃᐅᔨᓴᖅᑎᑐᓂᑦ

WSCC CLAIM: WORKER'S REPORT OF INJURY

If there is a question that does not apply, please indicate by writing 'N/A'.

A – Worker Information

1. First Name	2. Last Name		
3. Mailing Address	4. Community		5. Postal Code
6. Residential Address (if different than above)	7. Date of Birth YY MM DD		8. Male ☐ Female ☐
9. Telephone (Include Area Code)	Cell	Fax	Email Address
10. Social Insurance Number	11. Single ☐ Married ☐ Common-Law ☐ Widowed ☐ Divorced ☐		
12. Number of Dependants	13. Job Title	14. Preferred Language ☐ English ☐ French ☐ Inuktitut ☐ Other	

B – Employer Information

15. Employer Name	16. Address
17. Supervisor's Name	18. Telephone ( )

C – Incident Details

19. Date of Incident YY MM DD Time: AM / PM	20. Place of Incident – Name of City/Town
21. Did incident occur on employer's premises? Yes ☐ No ☐	If no, where?
22. Date reported to employer YY MM DD Time: AM / PM	23. Name and position of person you reported incident to:
24. Date first disabled from work YY MM DD Time: AM / PM	

IMPORTANT

25. Please describe the incident in as much detail as possible. Include: where it took place; what you were doing; what equipment you were using; and, whether gas, chemicals, or extreme temperatures were involved. *(Attach sheet if necessary)*

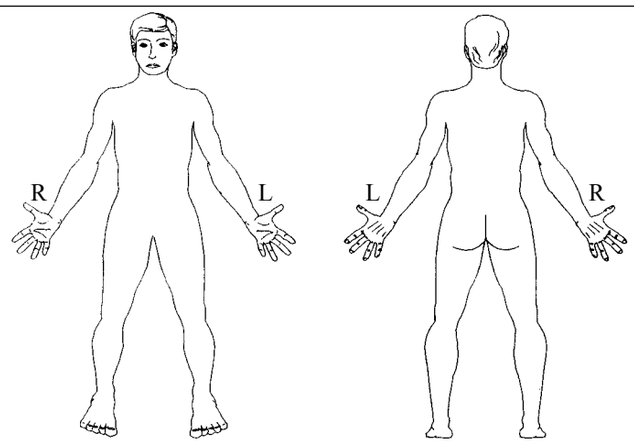
_____
_____
_____
_____

What part of the body was injured? (left/right side, hand, eye, back, etc.)

_____

What type of injury? (sprain, bruise, fracture etc.)

_____



26. **IMPORTANT - Please list any witnesses** Name and Address – include a contact number	Name and Address – include a contact number

27. Have you been offered light duties? Yes ☐ No ☐	When? YY MM DD
28. Have you returned to work? Yes ☐ No ☐ If yes, ☐ Light Duties ☐ Regular Duties	When? YY MM DD
29. Name of Attendant if first aid was provided? Where?	When? YY MM DD
30. What Hospital / Health Care Centre did you go to?	When? YY MM DD
31. Name of attending Health Care Professional	

D. Past Injuries

32. Have you ever had an injury or disability to the same body part? (i.e. left foot, right hand)? Yes ☐ No ☐ When? YY MM DD
33. Have you had previous claims with this Commission, or any other Workers' Compensation Board? If yes, provide dates and nature of injury.

PLEASE PROCEED TO SECTION "E" AND "F" ON THE 2ND PAGE. →

Worker's Full Name:

E – Employment Category

34. Worker's Type of Employment	A) **Permanent**	B) **Non - Permanent**
	Type of Permanent Employment - ☐ Term (*Over 1 year*) ☐ Full / Part time Permanent ☐ Apprentice ☐ Relief ☐ Other	***Type of Non-Permanent Employment -*** ☐ Term (*Under 1 year*) ☐ Seasonal ☐ Summer Student ☐ Casual ☐ Apprentice
35. Is the job subject to seasonal layoffs? Yes ☐ No ☐		36. Is the job subject to lack of work layoffs? Yes ☐ No ☐
37. First day of hire YY MM DD		

F – Schedule Information *(Please complete all questions that apply)*

38. Number of days on _____ Number of days off _____	39. Hours per Shift / Day _____	40. Hours per Rotation _____
41. Please circle days on for one full rotation: M T W T F S S M T W T F S S M T W T F S S M T W T F S S 42. Date rotation started YY MM DD Date rotation ends YY MM DD		

If NO WORK WAS MISSED and NO CHANGE to duties or pay, proceed to bottom of page and sign, date, and submit this report.
If WORK WAS MISSED or if duties or pay have been MODIFIED, please answer ALL questions on this form.

G – Wage Information *(Please complete all questions)*

43. What is your hourly rate of pay? _____ / hr *If you are paid other than hourly or on salary please attach an explanation*	What is your annual gross earnings? _____
44. Do you receive any other benefits? Yes ☐ No ☐ (eg: Vacation pay, Northern Allowance, Bonus)	**If yes, explain in detail with amounts or averages:**
45. Do you regularly work or get paid for overtime? Yes ☐ No ☐	
46. Provide an estimate of regular overtime hours _____ / *Please circle* day week month	47. What is your overtime rate? _____ / hr
48. Are you being paid for lost time? Yes ☐ No ☐	
49. Do you have a second job? Yes ☐ No ☐ If yes, have you missed time from this job due to your injury? Yes ☐ No ☐ *(If you have more than one other employer please list all employers and their contact information)* Name of second employer: _____ Contact name and phone: _____	

WORKER'S CONSENT

I hereby claim compensation for work-related injuries or disease.

Information Sharing- I understand that the above information about me will be used by the WSCC for the sole purpose of conducting an investigation into this claim. I also understand that the WSCC will need to gather more information about my work incident and medical and work history to administer my claim. For that specific purpose only, some personal information may have to be disclosed to employers, medical personnel and other relevant third parties.
I authorize the WSCC to provide and gather such information from all necessary sources, including hospital and doctors' records, and employer records.

Information Accuracy- I understand that incomplete information from me may delay my claim, and that untrue information from me is unlawful.
I declare the information above is true and accurate. I understand it may be a criminal offence to make a false claim, or to work and earn income while receiving workers' compensation without telling the WSCC.

Signature: _____ Date: _____

Witness: _____ Date: _____

For more information on our Legislation and Policies, please visit our Website
www.wscc.nt.ca • www.wscc.nu.ca

If you would like assistance filling in this form, or more information, please contact one of our offices listed below

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax: 1-866-277-3677
or
Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407• Fax: (867) 979-8531 • Toll Free Fax: 1-866-979-8501
www.wscc.nt.ca or **www.wscc.nu.ca**

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YELLOWKNIFE EDUCATION DISTRICT NO. 1
OF THE NORTHWEST TERRITORIES

BOX 788
YELLOWKNIFE, NT X1A 2N6
TEL: (867) 766-5050 FAX: (867) 873-5051

EDUCATING FOR LIFE.

Functional Abilities Form

To be completed by Employee:

Patient Name: _____

Medical Diagnosis: _____ Date of Assessment: _____

By signing below, I am authorizing any health professional who treats me to provide me and my employer with information about my functional abilities on this form.

_____ _____

Signature **Date**

To be completed by Health Professional:

SECTION A

Please check one box:

	Patient is capable of returning to work with **NO RESTRICTIONS**
	Patient is capable of returning to work **WITH RESTRICTIONS**. Complete Sections **B and C**.
	Patient is physically unable to return to work at this time. Complete **Section C.**

SECTION B

1. Please indicate **Abilities** that apply, including additional details in section 3:

Walking:		Standing:		Sitting:		Lifting from floor to waist:	
	Full Abilities		Full Abilities		Full Abilities		Full Abilities
	Up to 100 meters		Up to 15 minutes		Up to 30 minutes		Up to 5 kgs
	100 to 200 meters		15 – 30 minutes		30 minutes – 1 hr		5-10 kgs
	Other (specify)		Other (specify)		Other (specify)		Other (specify)

Lifting from waist to shoulder:		Stair Climbing:		Ladder climbing:	
	Full Abilities		Full Abilities		Full Abilities
	Up to 5 kgs		Up to 5 steps		1-3 steps
	5-10 kgs		5 -10 steps		4 - 6 steps
	Other (specify)		Other (specify)		Other (specify)

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EDUCATING FOR LIFE.

Functional Abilities Form

2. Please indicate **Restrictions** that apply, include additional details in section 3:

☐ Bending/twisting repetitive movement of (please specify):

_____

_____

☐ Work at or above shoulder activity:

_____

_____

☐ Chemical exposure to:

_____

_____

☐ Environmental exposure to: (e.g. heat, cold, noise or scents)

_____

_____

☐ Limited use of hands (s):

Left		Right
	Gripping	
	Pinching	
	Other (please specify)	

☐ Limited pushing/pulling with

	Left Arm
	Right arm
	Other (please specify)

☐ Exposure to vibration:

	Whole body
	Hand/arm

☐ Operating motorized equipment: (e.g. forklift)

_____

_____

☐ Potential side effects from medications: (please specify)

_____

_____

3. Additional Comments on **Abilities and/or Restrictions**:

_____

_____

_____

4. From the date of this assessment, the above **Abilities and/or Restrictions** will apply for approximately:

☐ 1 – 2 days ☐ 3 – 7 days ☐ 8 – 14 days ☐ 14 - 28 days ☐ 28 + days

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EDUCATING FOR LIFE.

Functional Abilities Form

5. Have you discussed return to work with your patient? ☐ Yes ☐ No

6. Recommendations for work hours and start date:

☐ Regular full-time hours ☐ Modified hours ☐ Graduated Hours

Start Date: _____
dd / mm / yyyy

SECTION C

Date of Next Appointment to review Abilities and/or Restrictions: _____
dd / mm / yyyy

Physician Name: _____

Physician Telephone: _____

Physician's Signature: _____