KAWARTHA PINE RIDGE DISTRICT SCHOOL BOARD

FUNCTIONAL ABILITIES FORM

CONFIDENTIAL

PART 1	
Part 2 of this form is to provide the Employer with information to assess whether the employee is able to perform the essential duties of their position and to understand restrictions and/or limitations to assess workplace accommodation if necessary.	The Board may request this medical confirmation in accordance with Article C6.1 h) Part 2 need only be completed for a return to work that requires an accommodation
I _____, hereby authorize my Health Care professional(s) _____ to disclose medical information to my employer, _____ . In order to determine my ability to fulfill my duties as a _____ from a medical standpoint, and whether my medical situation is such that it can support my sustained return to work in the foreseeable future. To this end, I specifically authorize my Health Care Professional(s) to respond to those questions from my employer set out in the medical certificate dated _____dd_____mm_____yyyy for my absence starting on the _____dd_____mm_____yyyy	**Dear Health Care Professional,** Please be advised that the Employer has an accommodation and return to work program. The parties acknowledge that the employer has an obligation to provide reasonable accommodation to the point of undue hardship, and that the employee has an obligation to cooperate with reasonable accommodation measures. Consistent with this understanding, and with the objective of returning employees to active employment as soon as possible, we would ask the medical professional to provide as full and detailed information as possible. Please return the completed form to the attention of: **Telephone No:**

Employee Signature:	
Employee ID:	**Date:**
Work Address:	**Work Location:**

Health Care Professional: The following information should be completed by the Health Care Professional	
First Day of Absence:	
General Nature of Illness (***please do not include diagnosis***):	
Date of Assessment: **dd mm yyyy**	No limitations and / or restrictions ☐ Return to work date: **dd mm yyyy** **For limitations and / or restrictions, please complete Part 2.**

PART 2: Physical and / or Cognitive Abilities

Health Care Professional to complete. Please outline your patient's abilities and/or restrictions based on your objective medical findings. (*please complete all that is applicable)*

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 ☐ Other (*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 ☐ Other (*please specify*):	**Right Hand** ☐ Gripping ☐ Pinching ☐ Other (*please specify*):
☐ **Bending/twisting** repetitive movement of (*please specify*):	☐ **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

ABILITIES FORM **CONFIDENTIAL**

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 (not able to do) and/or Restrictions (<u>should/must</u> not do) for all medical conditions**:

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

From the date of this assessment, the above will apply for approximately:

☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days ☐ Permanent

Have you discussed return to work with your patient?

☐ Yes ☐ No

Recommendations for work hours and start date (if applicable):

☐ Regular full time hours ☐ Modified hours ☐ Graduated hours

Start Date: **dd** **mm** **yyyy**

Is patient on an active treatment plan?: ☐ Yes ☐ No

Has a referral to another Health Care Professional been made?

☐ Yes (optional - please specify): _____ ☐ No

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

Please check one:

☐ Patient is capable of returning to work with no restrictions

☐ Patient is capable of returning to work with restrictions (Complete Part 2)

☐ I have reviewed Part 2 above and have determined that the Patient is totally disabled and is unable to return to work at this time.

Recommended date of next appointment to review Abilities and/or Restrictions: dd mm yyyy

PART 3: Confirmation and Attestation
Health Care Professional: The following information should be completed by a Health Care Professional

I confirm all of the information provided in this attestation is accurate and complete: ☐

Completing Health Care Professional Name:
(Please Print) _____

Date: _____

Telephone Number: _____

Signature: _____

CONFIDENTIAL - PLEASE RETURN THE COMPLETED FORM TO OUR EMAIL:

employeehealthservices@kprdsb.ca

"General Nature of Illness" (or injury) suggests a general statement of a person's illness or injury in plain language without any technical medical details, including diagnosis. Although revealing the nature of an illness may suggest the diagnosis, it will not necessarily do so. "Nature of illness" and "diagnosis" are not congruent terms. For example, a statement that a person has a cardiac or abdominal condition or that s/he has undergone surgery in that respect reveals the essence of the situation without revealing a diagnosis.

Additional or follow up information may be requested as appropriate.