APPENDIX B – ABILITIES FORM – OSSTF, PSSP, CEI, CET

Employee Union Group:	**Requested By**:
WSIB Claim: ☐ Yes ☐ No	**WSIB Claim Number** (if applicable):

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 accommodations if necessary.

Employee's Consent: I authorize the Health Professional involved with my treatment to provide my employer with 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:	**Employee Phone #**:
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 sections 2 (A&B) and 3.**

☐ I have reviewed section 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 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):

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

2A. 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 to 1 hour ☐ Other (please specify):	**Stair Climbing**: ☐ Full abilities ☐ Up to 5 steps ☐ 6 – 12 steps ☐ Other (please specify):

Lift from floor to waist: ☐ Full abilities ☐ Up to 5 kilograms ☐ 5 – 10 kilograms ☐ Other (please specify):	**Lift from waist to shoulder**: ☐ Full abilities ☐ Up to 5 kilograms ☐ 5 – 10 kilograms ☐ Other (please specify):	**Travel to Work**: Ability to use public transit: ☐ Yes ☐ No Ability to drive: ☐ Yes ☐ No

☐ **Bending/twisting –** repetitive movement of (please specify):	☐ **Work at or above shoulder activity**:	☐ **Chemical exposure to**:	☐ **Use of hand(s)**: **Left hand**: ☐ Gripping ☐ Pinching ☐ Other (please specify):	**Right hand**: ☐ Gripping ☐ Pinching ☐ Other (please specify):

2B. COGNITIVE (please complete all that apply):			
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 (ex. 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:			

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 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 the 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 was made, will you continue to be the patient's primary Health Care Provider? ☐ Yes ☐ No	
4. Recommended date of next appointment to review abilities and/or restrictions:	
dd/mm/yyyy:	

Completing Health Care Professional's Name: (Please Print) _____

Telephone: _____ **Fax**: _____

Date: _____ **Signature**: _____

Please submit completed form to:
Abilities & Wellness Services
Fax: 519-452-2606
Email: medicalnote@tvdsb.ca