APPENDIX F
Sample medical ability to work form

The purpose of this form is to provide the patient with the necessary information that they need to give to their employer to help the employer make decisions about accommodating the patient, providing disability leave, or assessing if the patient can return to work.

When completing this form, disclose only information necessary to meet the purpose of the form. Typically, it is not necessary to provide a diagnosis or treatment information.

Physician's name and address:

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I saw _____________________________ (patient's name) on__________________(date)

Date of injury or illness, if applicable__________________________

This patient is medically able to work with limitations or restrictions as of

_____________________ (date).

Restrictions or limitations (see Sections A and B for details)

In my opinion, the restrictions or limitations indicated in Section A are:

❑ Temporary:

❑ _____days

❑ less than 2 weeks

❑ 2 to 4 weeks

❑ 4 to 6 weeks

❑ 6 weeks to 3 months

❑ more than 3 months

❑ Permanent: Date of next appointment ____________________________________

My opinion is based on the factors indicated below:

❑ Information provided by the patient

❑ My examination of the patient and my assessment of the findings and health information

I have provided this form to the patient named above

______________________________ ______________

Physician's signature Date

SECTION A:

PHYSICAL	Restriction	Limitation	MENTAL	Restriction	Limitation
sitting			Thinking/ reasoning		
standing			concentration		
walking			memory		
lifting			critical decision-making		
carrying			interpersonal contact		
Pushing/ pulling			alertnes		
climbing stairs			other (specify in section b)		
climbing ladders			**ENVIRONMENTAL**		
climbing scaffolding			exposure to heat/cold		
crouching			exposure to dust/fumes/odor		
crawling			exposure to chemicals		
Kneeling			food handling		
Bending/ Twisting/ Turning			other (specify in section b)		
repetitive activity			**OTHER**		
sustained postures			shift/attendance duration		
gripping			consecutive shift attendance		
reaching			shift work		
Fine dexterity			overtime		
balance			operating vehicle		

Vision/ hearing/ speech			operating equipment		
other (specify in section b)			working heights		
			other (specify in section b)		

Specific Functional Restrictions and/or Limitations

Patient's name ________________________________

Does the patient require medical aids (e.g. splint, brace) or personal protective equipment (e.g. gloves, mask)?

❏ No ❏ Yes (specify in section B)

SECTION B:

Please provide necessary details about any restrictions or limitations you have identified.
It is not necessary to provide a diagnosis or treatment information.

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I have provided this form to the patient named above.

____________________________________ ____________________________

Physician's signature date