

ASSESSMENT OF WORK ABILITIES FORM

PLEASE FILL OUT ALL FIELDS AND SUBMIT TO HR@SELKIRK.CA AND HEALTHANDSAFETY@SELKIRK.CA

PHYSICIAN NOTE: Selkirk College provides accommodation to ill or injured employees.

1. **Please do not provide diagnosis or treatment.**
2. Information on this form will be used to assist the employee's return to work.
3. This form will be held in confidence by Selkirk College Human Resources with the understanding that only pertinent information required to ensure successful return to work will be shared with your patient's supervisor or other non-medical staff at Selkirk College.

DATE: _____

TO BE COMPLETED BY PHYSICIAN

Patient Name: _____

This person has been under my care for an illness or injury, which has prevented/limited his/her attendance at work on the following dates:

Please check one of the following - This person is:

- Able to return to work without limitation.
- Unable to return to work.
Estimated return to work date: _____
- Able to return to work with the following limitations.
(If this box is checked, please complete the entire section below, checking all that apply.)

ASSESSMENT OF WORK ABILITIES: TO BE COMPLETED BY QUALIFIED PROFESSIONAL

DEMAND	LIMITATIONS
<input type="checkbox"/> Twist / Turn	
<input type="checkbox"/> Bend	
<input type="checkbox"/> Climb	
<input type="checkbox"/> Walk	
<input type="checkbox"/> Sit	
<input type="checkbox"/> Squat	
<input type="checkbox"/> Stand	
<input type="checkbox"/> Balance	
<input type="checkbox"/> Push / Pull	
<input type="checkbox"/> Lift: <input type="checkbox"/> Floor to waist <input type="checkbox"/> Waist to shoulder <input type="checkbox"/> Above shoulder	
<input type="checkbox"/> Work Hours	
<input type="checkbox"/> Work Shifts	
<input type="checkbox"/> Working at Heights	
<input type="checkbox"/> Neck	
<input type="checkbox"/> Shoulder	
<input type="checkbox"/> Wrist	
<input type="checkbox"/> Grip	

REQUEST FOR WORKPLACE ACCOMMODATION FORM

PLEASE FILL OUT ALL FIELDS AND SUBMIT TO HUMAN RESOURCES.

ASSESSMENT OF WORK ABILITIES: TO BE COMPLETED BY QUALIFIED PROFESSIONAL

DEMAND	LIMITATIONS
<input type="checkbox"/> Judgment	
<input type="checkbox"/> Ability to provide Supervision	
<input type="checkbox"/> Ability to provide Instruction	
<input type="checkbox"/> Public Contact	
<input type="checkbox"/> Multiple Tasks	
<input type="checkbox"/> Concentration	
<input type="checkbox"/> Hearing	
<input type="checkbox"/> Speech	
<input type="checkbox"/> Operating Machinery / Motor	
<input type="checkbox"/> Other	

ESTIMATED DURATION OF RESTRICTIONS

<input type="checkbox"/> Days
<input type="checkbox"/> 2 - 4 weeks
<input type="checkbox"/> 4 - 6 weeks
<input type="checkbox"/> 6 - 8 weeks
<input type="checkbox"/> 8 - 10 weeks
<input type="checkbox"/> > 10 weeks
<input type="checkbox"/> Long Term, estimated weeks
<input type="checkbox"/> Permanent

This employee will have to attend appointments at the following intervals:

Name of Physician

Date

Physician Signature

STAMP
(If Applicable)