ASSESSMENT OF WORK ABILITIES FORM

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

HUMAN RESOURCES

Selkirk College

DATE: _____

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.

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
☐ Twist / Turn	
☐ Bend	
☐ Climb	
☐ Walk	
☐ Sit	
☐ Squat	
☐ Stand	
☐ Balance	
☐ Push / Pull	
☐ Lift: ☐ Floor to waist ☐ Waist to shoulder ☐ Above shoulder	
☐ Work Hours	
☐ Work Shifts	
☐ Working at Heights	
☐ Neck	
☐ Shoulder	
☐ Wrist	
☐ Grip	

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DEMAND	LIMITATIONS
☐ Judgment	
☐ Ability to provide Supervision	
☐ Ability to provide Instruction	
☐ Public Contact	
☐ Multiple Tasks	
☐ Concentration	
☐ Hearing	
☐ Speech	
☐ Operating Machinery / Motor	
☐ Other	

ESTIMATED DURATION OF RESTRICTIONS
☐ Days
☐ 2 - 4 weeks
☐ 4 - 6 weeks
☐ 6 - 8 weeks
☐ 8 - 10 weeks
☐ > 10 weeks
☐ Long Term, estimated weeks
☐ Permanent

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

Name of Physician _____ Date _____ Physician Signature _____

STAMP
(If Applicable)