

Physical Functional Abilities for a Safe Return to Work

Please return completed form to your patient prior to the end of the appointment.

To be completed in keeping with *Section 40 (2) Medical Information to Third Parties and Sickness Certificates* from *Bylaw 11 Standards of Practice of Medicine*, Manitoba College of Physicians and Surgeons.

Dear Healthcare Professional:

The patient you are about to treat sustained an injury/illness at work. This letter is to request your assistance to help us return our team member to safe accommodations at work while they are recovering from their injury/illness.

To assist injured/ill employees, we provide a comprehensive alternate work program, at no base wage loss to the employee. All return to work plans are created in collaboration with our team member, you – the treating healthcare provider, the team member's supervisor, the Health and Safety Department and the Workers Compensation Board (WCB).

Due to our various operations, we are fortunate to be able to offer a wide range of work accommodations. **These include the ability to take more frequent breaks, work reduced hours, as well as modified or alternate work which can include sedentary duties if required.**

We have had an opportunity to discuss the Return to Work Program with this employee, but would also appreciate your support and involvement so that we may have a complete understanding of recommended abilities and limitations.

Please complete the attached Physical Functional Abilities Form to assist us in providing a tailored work program for your patient. Please return this form to your patient prior to the end of the appointment. If there are charges for the completion of the form we would be pleased to pay you directly; alternatively, should your patient pay for the form, please provide them with a paid in full receipt for us to reimburse them.

If there is a concern about any duties which may be available, please note them on the form and we will ask the WCB to contact you directly for clarification.

Thank you for your assistance in treating our team member and helping us return them back to work quickly and, most importantly, safely.

Should you have any questions, please contact me at any time.

NAME:

TITLE:

COMPANY:

PHONE NUMBER:

Physical Functional Abilities Form - Modified Duties Available

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Patient Name	Date of Appointment
Area(s) of Injury	Is the patient fit for full regular duties? (If no, complete next sections.) <input type="checkbox"/> Yes <input type="checkbox"/> No

Weight Restrictions	Full Ability		11-25kgs / 24-55lbs		6-10kgs / 13-23lbs		Up to 5kgs / 12lbs	
	Spine	Extremity	Spine	Extremity	Spine	Extremity	Spine	Extremity
Lift/Carry - Floor to Waist	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R
Lift/Carry - Waist to Shoulder	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R
Lift/Carry - Above Shoulder	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R
Push/Pull	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R	<input type="checkbox"/>	L R

If abilities above are frequent, occasional or other, please outline details in comments section.

Activities	Full Ability	Frequently (up to 66% / day)	Occasionally (up to 33% / day)	Should Not Perform
Walk				
Stand				
Sit/Sedentary				
Climb (Stairs/Ladder)				
Bend				
Twist				
Squat				
Kneel				
Grip/Grasp	L R	L R	L R	L R
Hand Dexterity	L R	L R	L R	L R
Reach Overhead	L R	L R	L R	L R
Reach Below Shoulder	L R	L R	L R	L R
Repetitive Motion	L R	L R	L R	L R
Driving (If no please explain)				
Use Public Transportation				

Based on the above abilities is the patient capable of performing modified or alternate duties? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please provide rationale for total disability:	
Estimated duration of limitations:	Complete recovery expected: <input type="checkbox"/> Yes <input type="checkbox"/> No
Recommended work hours: Full Time Hours Reduced Hours (Please provide daily/weekly schedule.)	
Reassessment date:	Additional comments:
Healthcare Professional Name/Address/Phone/Fax or STAMP	
Date	

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