HUMAN RESOURCES
OCCUPATIONAL HEALTH AND WELLNESS

Functional Capacity Form

Occupational Health & Wellness

Phone: 519-824-4120 ext. 52647 *Fax: 519-780-1796* *E-Mail: ohw@uoguelph.ca*

The University is committed to making every reasonable effort to assist ill or injured employees in their return to work. The University is also responsible in meeting its legal requirements for accommodations and making every reasonable effort to accommodate its employees. Please provide the following information to assist us in planning for your patient's safe return to work.

Section A: Employee Information *(to be completed by employee)*

NAME: (Surname)	(Given Names)	Date of Birth (DD/MM/YYYY)
HOME ADDRESS: (Street, City, Postal Code)	HOME/CONTACT PHONE NO.	
FACULTY/SCHOOL/SERVICE	DEPARTMENT	JOB TITLE
MANAGER/SUPERVISOR NAME	PHONE NO.	

Section B: Medical Information (to be completed by a qualified health care treatment provider)

Please be advised that by completing this form you are certifying that the information is true and accurate and is in keeping with professional standards outlined by the professional and regulatory bodies that govern your practice. Please **fully** complete the following boxes as appropriate to identify your patient's capabilities/limitations to ensure the employer can determine the employee's accommodation.

☐ Employee fit for full duties Effective Date: ______________________________________

☐ Employee fit for modified duties (See Functional Abilities below). Effective Date: ______________________________________

Duration: ________________________________ Reassessment Date: ____

☐ Employee fit modified hours - specify:____

Duration: ________________________________ Reassessment Date: ____

Please identify your patient's current capabilities/limitations:

Capabilities:

Walking:	☐ full abilities	☐ Up to 100 m	☐ 100-200m	☐ other ______________
Standing:	☐ full abilities	☐ Up to 15 mins	☐ 15-30 mins	☐ other ______________
Sitting:	☐ full abilities	☐ Up to 30 mins	☐ 30mins – 1 hr	☐ other ______________
Lifting floor to waist:	☐ full abilities	☐ Up to 5 kgs	☐ 5 – 10 kgs	☐ other ______________
Lifting waist to shoulder	☐ full abilities	☐ Up to 5 kgs	☐ 5 – 10kgs	☐ other ______________
Stair climbing:	☐ full abilities	☐ Up to 5 steps	☐ 5 – 10 steps	☐ own pace ☐ as tolerated
Ladder climbing:	☐ full abilities	☐ 1 – 3 steps	☐ 4 – 6 steps	☐ own pace ☐ as tolerated
Hand use (R/L):	☐ gripping	☐ pinching	☐ fine motor	☐ other ______________

Limitations: Please indicate restrictions that apply.

☐ Bending/twisting repetitive movement of (please specify)	☐ Work at or above shoulder activity:	☐ Chemical Exposure to:	☐ Environmental exposure to: (e.g. heat, cold, noise or scents)	☐ Kneeling or Squatting

NAME: (Surname)	(Given Names)	Date of Birth (DD/MM/YYYY)

Limitations: Please indicate restrictions that apply.

☐ Limited pushing/pulling with: ☐ Left Arm ☐ Right Arm ☐ Other (please specify)	☐ Operating motorized equipment: (e.g. forklift)	☐ Potential side effects from medications (please specify) Do not include names of medications.	☐ Exposure to vibration: ☐ Whole body ☐ Hand/Arm

☐ Other

____

Cognitive Functional Limitations (<u>IF APPLICABLE</u>): Please indicate the cognitive limitations and associated severity.

Function	Degree of Impairment None	Degree of Impairment Mild	Degree of Impairment Moderate	Degree of Impairment Severe
Multi-tasking				
Memory				
Attend to deadline pressures				
Critical decision making				
Working with others				
Dealing with confrontation				
Dealing with emotional situations				
Other: ___________________________________				

Additional Comments:

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____
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By affixing my signature below, I certify that I am a qualified healthcare provider and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

TREATMENT PROVIDER NAME: (Please Print) ___________________________ PROFESIONAL DESIGNATION: ______________________

ADDRESS: ____ FAX: ___________________________________

SIGNATURE: ____ **DATE:** _________________________________

Once competed please return <u>by Secure Drive or fax</u> to Occupational Health and Wellness at OHW Secure Drive or (519) 780-1796.

<u>Any costs associated with providing the above information will be the responsibility of the employee.</u>