Appendix 11

Return to Work Form

I, _____ , hereby authorize the healthcare professional who treats me to provide my employer, _____ , with information about my capabilities and limitations on this return to work form, as it relates to remaining at work, returning to work, or accommodations at work.

Employee's signature: _____ Date of signature: _____

_____-

Dear Healthcare Practitioner, Be In Christ Church of Canada offers a return-to-work program for employees experiencing non-work-related injuries and illness. Your feedback will allow us and our employee to consider an appropriate workplace accommodation if necessary.

Please fax, email, or mail the completed form to the attention of

_____

Please select on of the following options:

□ 1. Employee is able to return to regular work with no restrictions, immediately.

□ 2. Employee is totally disabled from working at this time, due to the restrictions noted below.

□ 3. Employee is able to return to work with the restrictions noted below.

Please indicate employee abilities or limitations that need to be considered when creating a return-to-work plan.

Walking:
□ Full abilities
□ Up to 100 metres
□ 100-200 metres
□ Other (please specify)

Standing:
□ Full abilities
□ Up to 15 minutes
□ 15-30 minutes
□ Other (please specify)

Sitting:
□ Full abilities
□ Up to 30 minutes
□ 30 min - 1 hour
□ Other (please specify)

Travelling to work:
Ability to use public transportation
□ Yes □ No
Ability to drive a car
□ Yes □ No

Using hand(s):
□ Full abilities
□ Limited dexterity
□ Limitations (please specify)

Using computer:
□ Full abilities
□ Up to 30 minutes
□ Limitations (e.g., vision) (please specify)

Stair climbing:
□ Full abilities
□ Up to 5 steps
□ 5-10 steps
□ Other (please specify)

Lifting from floor to waist:
□ Full abilities
□ Up to 5 kilograms
□ 5-10 kilograms
□ Other (please specify)

Please indicate if the employee requires accommodation for any of the cognitive dimensions listed below.

			Please describe or comment on limitations
Alertness	☐- No	☐- Yes	_____
Attention	☐- No	☐- Yes	_____
Orientation	☐- No	☐- Yes	_____
Judgement	☐- No	☐- Yes	_____
Memory	☐- No	☐- Yes	_____
Mood	☐- No	☐- Yes	_____
Psychomotor functions	☐- No	☐- Yes	_____

Estimated duration of limitations: _____

Date employee will be reassessed: _____

Complete recovery expected: ☐- Yes ☐- No ☐- Unknown at this time

Recommendations for work hours: ☐- Full-time hours ☐- Modified hours ☐- Graduated hours

(Please clarify any recommendations for modified or graduated house in the additional comments section).

Additional comments on abilities and/or limitations: _____

_____

_____

Name of attending healthcare provider (print): _____

Signature of attending healthcare provider: _____

Date of signature: _____