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| --- |
| **A. Section A to be completed by the employee** |
| By signing below, I am claiming benefits under NOSM University’s Short Term Disability Plan, for a non-work related injury or disease. I am also authorizing a health practitioner (as defined by Article 31 (d) in the OPSEU Unit 2 Collective Agreement) who treats me to provide me, my employer, and Human Resources information about my functional abilities on the Employer’s Functional Abilities report. |
|  |
| Name: |  | Signature: |  |
| Date: |  |  |
|  |  |  |

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| --- | --- |
| **B. Section B to be completed by the employer** |  |
|  |  |
| Employee #: |  | Date of Birth: |  | Unit/Portfolio: |  |
|  |  |
| Job Title: |  | Location: |  |
|  |  |
| **Employer Contact** |
| **Laurie Twilley****HR Coordinator (Payroll, Pension & Benefits)**NOSM UniversityPHONE (705) 662-7138FAX (705) 671-3880**Email:** payroll@nosm.ca  |
|  |
|  |  |  |
| **C. Health Practitioner’s Information** |  |
|  |
| Health Practitioner’s Designation: |
| [ ]  Chiropractor | [ ]  Physician | [ ]  Physiotherapist | [ ]  Registered Nurse | [ ]  Other: |  |
|  |  |  |
| Health Practitioner’s Name (please print): |  |
| Address: |  |
| City, Prov, Postal Code: |  |
| Phone Number: |  |
| Fax: |  |
|  |  |
|  |  |
|  |  |
| Signature: |  | Date: |  |
|  |
| **D. Section C to be completed by the Health Professional** |  |
|  |  |
| Date of Assessment: |  |  |  |
|  |  |
| Please check one: | [ ]  Patient is capable of returning to work with **no restrictions** | [ ]  Patient is capable of returning to work with **restrictions**. Complete Section E & F | [ ]  Patient is physically unable to return to work at this time. Complete **Date of Next Appointment** Section F |
|  |  |  |  |
| **E. Abilities and/or Restrictions** |  |
| 1. Please indicate **Abilities** that apply. Include additional details in the comments below. |
|  |
| **Walking:** | **Standing:** | **Sitting:** | **Lifting from floor to waist:** |
| [ ]  Full Abilities | [ ]  Full Abilities | [ ]  Full Abilities | [ ]  Full Abilities |
| [ ]  Up to 100 metres | [ ]  Up to 15 minutes | [ ]  Up to 30 minutes | [ ]  Up to 5 kilograms |
| [ ]  100 – 200 metres | [ ]  15 – 30 minutes | [ ]  30 minutes – 1 hour | [ ]  5 – 10 kilograms |
| [ ]  Other (please specify in the comments below) | [ ]  Other (please specify in the comments below) | [ ]  Other (please specify in the comments below) | [ ]  Other (please specify in the comments below) |
|  |  |  |  |
| **Lifting from waist to shoulder:** | **Stair Climbing:** | **Ladder Climbing:** | **Travel to work:** |
| [ ]  Full Abilities | [ ]  Full Abilities | [ ]  Full Abilities | Ability to use public transit | Ability to drive a car |
| [ ]  Up to 5 kilograms | [ ]  Up to 5 steps | [ ]  1 – 3 steps |  |  |
| [ ]  5 – 10 kilograms | [ ]  5 – 10 steps | [ ]  4 – 6 steps | [ ]  Yes | [ ]  Yes |
| [ ]  Other (please specify in the comments below) | [ ]  Other (please specify in the comments below) | [ ]  Other (please specify in the comments below) | [ ]  No | [ ]  No |
|  |  |  |  |  |
| 2. Please indicate **Restrictions** that apply. Include additional details in the comments below. |
|  |
| [ ]  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) | [ ]  Limited use of hand(s): |
|  |  |  |  | Left |  | Right |
|  |  |  |  |[ ]  Gripping |[ ]
|  |  |  |  |[ ]  Pinching |[ ]
|  |  |  |  |[ ]  Other (please specify) |[ ]
|  |
| [ ]  Limited pushing/pulling with: | [ ]  Operating motorized equipment: (e.g. Forklift) | [ ]  Potential side effects from medications (please specify) Do not include names of medications. | [ ]  Exposure to vibration: |
|  | [ ]  Left Arm[ ]  Right Arm[ ]  Other (please specify) |  |  |  | [ ]  Whole body[ ]  Hand/’Arm |
|  |  |  |  |  |  |
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|  |
| 3. Additional Comments on **Abilities and/or Restrictions**. |
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| 4. From the date of this assessment, the above will apply for approximately: | 5. Have you discussed return to work with your patient? |
| [ ]  1 – 2 days | [ ]  3 – 7 days | [ ]  8 – 14 days | [ ]  14+ days | [ ]  Yes | [ ]  No |
| 6. Recommendations for work hours and start date: | [ ]  Regular full-time hours | [ ]  Modified hours | [ ]  Graduated hours | [ ]  Start Date: |  |
| **F. Date of Next Appointment** |
|  |  |
| Recommended date of next appointment to review **Abilities and/or Restrictions** : |  |
|  |
| **G. Cognitive/Emotional Wellness** |
|  |  |
| Does the Employee have cognitive functional limits? | ☐ Yes (please specify below)☐ Not applicable |
|  |  |
| Please describe in the space below if the Employee has any Cognitive Functional limits related to judgement, concentration, decision making, attention, communication, ability to work independently, with Supervision or any other limits. |
|  |
|  |
|  |
| Does the employee require additional Mental Health support to facilitate a successful return to work? |
|  |
|  |
|  |
|  |
| Complete Recovery expected? | [ ]  Yes [ ]  No | Estimated Duration of Limitations: | [ ]  up to 2 weeks[ ]  up to 3 months[ ]  3 months + |