MEDICAL PRACTITIONER'S REPORT
WORKPLACE CAPABILITIES/RETURN TO WORK

Dear Dr.___________________________________

Frontier School Division accommodates employees to aid in the early and successful rehabilitation of ill or injured workers. In order to identify appropriate work, Frontier School Division requests your assistance by completing this form, which will provide the employee with duties within the employee's capabilities given your assessment of his/her capabilities. Please complete Sections A, B, C, as applicable. Your cooperation is appreciated.

This certifies that I have thoroughly examined ____
(Name of Patient)

Date of last attendance on employee ____

Section A

1. Does employee have a medical condition that would prevent him/her from attending work and performing his/her duties full-time as described in the attached job description?

   Yes______ No ______

   If Yes, can employee carry out his/her duties on a part-time basis with no restrictions:

   Yes ______ No ______

   If Yes, what percent of full time ________

Section B

2. Employee may return to modified work, with restrictions, as indicated below:

   Yes______ No ______ If Yes, please complete the following:

   a. Employee is able to do the following: (Please check column that applies)

Action	No Restrictions	Continuous 67% - 100%	Frequent 34% - 66%	Occasional Up to 33%	Not at all
Standing					
Walking					
Sitting					
Working with hands above shoulders					

Action	No Restrictions	Continuous 67% - 100%	Frequent 34% - 66%	Occasional Up to 33%	Not at all
Reaching within body envelope					
Reaching outside body envelope					
Bending					
Twisting					
Squatting					
Kneeling					
Climbing					
Repetitive hand/wrist/elbow: Right - flexion/extension - radial/ulnar deviation					
Left - flexion/extension - radial/ulnar deviation					
OTHER:					

b. Employee can lift/carry:

(a) Floor to waist: ❑ less than 2 kg ❑ 2 kg to 10 kg ❑ 10 kg to 23 kg ❑ No restrictions

(b) Waist to shoulder: ❑ less than 2 kg ❑ 2 kg to 10 kg ❑ 10 kg to 23 kg ❑ No restrictions

c. Is employee restricted by environmental factors such as heat/cold, dust, chemical fumes, etc.?

Yes ______ No ______ If Yes, please explain:

____

____

d. Is employee required to wear or use assistive equipment?

Yes ______ No ______ If Yes, please explain:

____

____

e. Is employee involved with treatment and/or medications that may affect his/her ability to perform some or all of the assigned duties or which could affect the safety of the employee or others?

Yes ______ No ______ If Yes, please explain:

____

____

f. Are there any other specific stressors/situations that would affect employee's ability to perform some or all of the assigned duties?

Yes ______ No ______ If Yes, please explain:

____

____

g. Additional information that you feel would be pertinent and beneficial in order to facilitate employee regularly attending work.

____

____

h. Recommendation for work hours:

_____ Full-time hours, OR ______ Graduated hours as follows:

______ number of hours for ______ number of weeks, increasing to:

______ number of hours for ______ number of weeks.

Employee will return to full-time work on ____________________________ OR

Date of next attendance on employee ____________________________

i. Has employee been referred to a specialist who would have relevant information concerning the employee's return to work?

Yes ______ No ______

If yes, referred to Dr. ____

Address____

Section C

Employee is totally disabled.

Estimated duration of absence from work: ______ Days ______ Weeks

Date of next attendance on employee: ___________________________

In accordance with the consent form attached, I provide this report to Frontier School Division and to employee.

Medical Practitioner's Name and Address: ____________________________________

____

____

Phone: _____________________________

Fax: _____________________________

___________________________________ Date: _______________________________
(Signature of Medical Practitioner)

Adopted September 1, 2009		