



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: _____

<input type="checkbox"/> Employee fit for modified duties (See Functional Abilities below). Effective Date: _____					
Duration: _____		Reassessment Date: _____			
<input type="checkbox"/> Employee fit modified hours - specify: _____					
Duration: _____		Reassessment Date: _____			
Please identify your patient's current capabilities/limitations:					
Capabilities:					
Walking:	<input type="checkbox"/> full abilities	<input type="checkbox"/> Up to 100 m	<input type="checkbox"/> 100-200m	<input type="checkbox"/> other _____	
Standing:	<input type="checkbox"/> full abilities	<input type="checkbox"/> Up to 15 mins	<input type="checkbox"/> 15-30 mins	<input type="checkbox"/> other _____	
Sitting:	<input type="checkbox"/> full abilities	<input type="checkbox"/> Up to 30 mins	<input type="checkbox"/> 30mins – 1 hr	<input type="checkbox"/> other _____	
Lifting floor to waist:	<input type="checkbox"/> full abilities	<input type="checkbox"/> Up to 5 kgs	<input type="checkbox"/> 5 – 10 kgs	<input type="checkbox"/> other _____	
Lifting waist to shoulder	<input type="checkbox"/> full abilities	<input type="checkbox"/> Up to 5 kgs	<input type="checkbox"/> 5 – 10kgs	<input type="checkbox"/> other _____	
Stair climbing:	<input type="checkbox"/> full abilities	<input type="checkbox"/> Up to 5 steps	<input type="checkbox"/> 5 – 10 steps	<input type="checkbox"/> own pace	<input type="checkbox"/> as tolerated
Ladder climbing:	<input type="checkbox"/> full abilities	<input type="checkbox"/> 1 – 3 steps	<input type="checkbox"/> 4 – 6 steps	<input type="checkbox"/> own pace	<input type="checkbox"/> as tolerated
Hand use (R/L):	<input type="checkbox"/> gripping	<input type="checkbox"/> pinching	<input type="checkbox"/> fine motor	<input type="checkbox"/> other _____	

Limitations: Please indicate restrictions that apply.

<input type="checkbox"/> Bending/twisting repetitive movement of (please specify)	<input type="checkbox"/> Work at or above shoulder activity:	<input type="checkbox"/> Chemical Exposure to:	<input type="checkbox"/> Environmental exposure to: (e.g. heat, cold, noise or scents)	<input type="checkbox"/> Kneeling or Squatting
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NAME: (Surname)	(Given Names)	Date of Birth (DD/MM/YYYY)
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Limitations: Please indicate restrictions that apply.

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| <input type="checkbox"/> Limited pushing/pulling with:
<input type="checkbox"/> Left Arm
<input type="checkbox"/> Right Arm
<input type="checkbox"/> Other (please specify) | <input type="checkbox"/> Operating motorized equipment: (e.g. forklift) | <input type="checkbox"/> Potential side effects from medications (please specify)
Do not include names of medications. | <input type="checkbox"/> Exposure to vibration:
<input type="checkbox"/> Whole body
<input type="checkbox"/> Hand/Arm |
|--|---|---|---|

Other

Cognitive Functional Limitations (IF APPLICABLE): 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:

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 completed please return by email or fax to Occupational Health and Wellness
 at ohw@uoguelph.ca or (519) 780-1796.

Any costs associated with providing the above information will be the responsibility of the employee.