

# PHYSICIAN'S ASSESSMENT OF WORK ABILITIES

**Note to Physician:**

Kwantlen Polytechnic University provides accommodation to ill or injured employees. The information on this form will be used to help the employee return to work. As this form may be shared with your patient's supervisor or other non-medical staff at Kwantlen Polytechnic University, **please do not provide diagnosis.**

**Employee Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

WORK ABILITIES					
DEMAND	FULLY ABLE	RESTRICTED	DEMAND	FULLY ABLE	RESTRICTED
• Judgement	<input type="checkbox"/>	<input type="checkbox"/>	• Operating machinery/motor	<input type="checkbox"/>	<input type="checkbox"/>
• Memory	<input type="checkbox"/>	<input type="checkbox"/>	• Operate a Vehicle	<input type="checkbox"/>	<input type="checkbox"/>
• Public/Student Contact	<input type="checkbox"/>	<input type="checkbox"/>	• Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
• Multiple Tasks	<input type="checkbox"/>	<input type="checkbox"/>	• Wrist	<input type="checkbox"/>	<input type="checkbox"/>
• Concentration	<input type="checkbox"/>	<input type="checkbox"/>	• Grip	<input type="checkbox"/>	<input type="checkbox"/>
• Ability to Provide Supervision	<input type="checkbox"/>	<input type="checkbox"/>	• Twist/Turn	<input type="checkbox"/>	<input type="checkbox"/>
• Ability to Receive Supervision	<input type="checkbox"/>	<input type="checkbox"/>	• Bend	<input type="checkbox"/>	<input type="checkbox"/>
• Able to deliver instruction	<input type="checkbox"/>	<input type="checkbox"/>	• Climb	<input type="checkbox"/>	<input type="checkbox"/>
If restricted suggest # of hours			• Balance	<input type="checkbox"/>	<input type="checkbox"/>
• Work Hours	<input type="checkbox"/>	<input type="checkbox"/>	• Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>
• Work Shifts	<input type="checkbox"/>	<input type="checkbox"/>	• Lift	<input type="checkbox"/>	<input type="checkbox"/>
• Sight	<input type="checkbox"/>	<input type="checkbox"/>	– Floor to Waist	<input type="checkbox"/>	<input type="checkbox"/>
• Hearing	<input type="checkbox"/>	<input type="checkbox"/>	– Waist to Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
• Speech	<input type="checkbox"/>	<input type="checkbox"/>	– Above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
• Neck	<input type="checkbox"/>	<input type="checkbox"/>	• Working at Heights	<input type="checkbox"/>	<input type="checkbox"/>
• Stand	<input type="checkbox"/>	<input type="checkbox"/>			
• Sit	<input type="checkbox"/>	<input type="checkbox"/>			
• Walk	<input type="checkbox"/>	<input type="checkbox"/>			

Date of examination on which the report is based: \_\_\_\_\_

Nature of illness (**not diagnosis**): \_\_\_\_\_

Is employee capable of returning to work immediately without restrictions? Yes \_\_\_\_\_ No \_\_\_\_\_ If "no" complete above section

Estimated duration of restrictions/partial incapacity: \_\_\_\_\_ Restrictions related to medications: (specify) \_\_\_\_\_

Rehabilitation/Treatment Required? Yes \_\_\_\_\_ No \_\_\_\_\_

This employee will need to attend appointments at the following intervals: \_\_\_\_\_

Estimated return to work date: \_\_\_\_\_

Comments: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

*(Please Print)*