# Functional Abilities Form

This form, when completed, is used to enable an employer to accommodate an ill or injured employee to remain at, or if absence is unavoidable, to return to work as soon as they are safely able to do so. It is an example of document that reflects best practices in obtaining information from health care practitioner in case of employee illness or injury, suitable for use anywhere in the federal public service.

## Section A – Employee's information (To be completed by the employee's supervisor)

| Employee Name: | PRI: | Classification: | Branch/Division: | Office/Location: |
|---|---|---|---|---|
| | | | | |

| Date of Injury/Illness (yyyy/mm/dd): | Injury/Illness is: ☐ Work Related ☐ Non-Work Related | ☐ First Occurrence, or ☐ Recurrence | Absence commenced: (yyyy/mm/dd) |
|---|---|---|---|
| Job title/occupation: | Employee's regular work hours: [*insert value*] hours/day; and [*insert value*] hours/week ☐ Seasonal: _____to | Supervisor's Name: | Supervisor's Tel # |

## Section B – Required work capacities (To be completed by the employee's supervisor)

The employee's regular work duties require the following physical and/or non-physical capacities. Please note: ratings are approximate.

(SECTION C - Limitations/Restrictions to be completed by attending Medical Practitioner or Treating Therapist)

### B.1) Movements of the spinal column

| | | | | |
|---|---|---|---|---|
| Lower Back: | ☐ Bending forward | ☐ Bending backward | ☐ Twisting | ☐ Side bending |
| Upper Back: | ☐ Bending forward | ☐ Bending backward | ☐ Twisting | ☐ Side bending |
| Neck: | ☐ Bending forward | ☐ Looking up | ☐ Rotation | ☐ Side bending |

Additional Information:

Limitations/Restrictions; ☐ No ☐ Yes (Specify in Section C)

### B.2) SITTING ACTIVITIES

☐ Desk work (reading, writing) - _____% of day
☐ Computer work - _____% of day
☐ Telephone use (☐ with headset) - _____% of day
☐ Other (e.g. lab work, equipment operation) - _____% of day
☐ Meetings -_____ % of day
☐ Driving -_____ % of day

Additional Information:

Limitations/Restrictions; ☐ No ☐ Yes (Specify in Section C)

### B.3) Standing activities

☐ Standing _____% of day, or _____hours/day: on _____ type of surface
☐ Walking - _____ distance,_____ hours/day: on _____ type of surface
☐ Balancing -activities requiring balancing: _____
☐ Stooping ☐ Crouching ☐ Squatting ☐ Kneeling
☐ Crawling ☐ Climbing (e.g., stairs, step ladders) - [*insert value*]
☐ Operating general office equipment (e.g., printer, photocopier, paper cutter)

Additional Information:

Limitations/Restrictions; ☐ No ☐ Yes (Specify in Section C)

### B.4) Lifting / carrying / pushing / pulling

| | Minimum weight | Maximum weight |
|---|---|---|
| ☐ Lifting from/to floor | _____ kg or _____ lbs | _____ kg or _____ lbs |
| ☐ Lifting from/to shoulder level or above | _____ kg or _____ lbs | _____ kg or _____ lbs |
| ☐ Carrying | _____ kg or _____ lbs | _____ kg or _____ lbs |
| ☐ Pushing | _____ kg or _____ lbs | _____ kg or _____ lbs |
| ☐ Pulling | _____ kg or _____ lbs | _____ kg or _____ lbs |

Additional Information:

Limitations/Restrictions; ☐ No ☐ Yes (Specify in Section C)

### B.5) Working with shoulders / elbows / wrists / hands / fingers

Reaching: ☐above shoulder level, ☐ below shoulder level, ☐ at shoulder level
Handling: ☐ fine objects, ☐ tools/objects requiring strong hand grip, ☐ vibrating tools/objects
☐ Typing _____ % of day ☐ Using Computer Mouse ☐ Filing
☐ Writing _____% of day ☐ Fingering

Additional Information:

Limitations/Restrictions; ☐ No ☐ Yes (Specify in Section C)

### B.6) Activities requiring senses

☐ Touch/feeling ☐ Speaking ☐ Hearing
☐ Colour vision ☐ Near vision ☐ Far vision
☐ Depth perception ☐ Smelling ☐ Tasting
☐ Driving ☐ Viewing computer screen - [*insert value*]% of day

Additional Information:

Limitations/Restrictions; ☐ No ☐ Yes (Specify in Section C)

### B.7) Physical work environment

☐ Indoors ☐ Closed office ☐ Open office (e.g. cubicle) ☐ confined space
☐ Outdoors ☐ Unfamiliar/unpredictable location(s) - _____% of day
Exposure to: ☐ weather, ☐ noise/distracting stimuli
Extreme: ☐ heat, ☐ cold
☐ Moisture (wet/humid) ☐ Dryness ☐ Fumes/vapours/dust
☐ Vibration ☐ Scented products ☐ Wildlife

Potential Hazards:

☐ Explosives ☐ Electric shock Radiation ☐ ionizing, ☐ non-ionizing
☐ Falling objects ☐ Sharp objects ☐ High, exposed places ☐ Sustained posture
☐ Intermittent noise ☐ Continuous noise ☐ Moving Mechanical Parts ☐ Awkward posture
☐ Physical violence ☐ Infectious exposure ☐ Waste handling ☐ Repetitive movements
☐ Biological/chemical contaminants ☐Handling of firearms ☐
☐ Handling heavy machinery or equipment Other:_____

Describe the type of Personal Protective Equipment used (if required) to protect against the physical work environment hazards:

Limitations/Restrictions; ☐ No ☐ Yes (Specify in Section C)

## B.8) Non-physical work-related capacities

**Schedule Demands:**

- ☐ Following a schedule, maintaining attendance/punctuality
- ☐ Shift work, rotating
- ☐ Deadlines: ☐ frequent, or ☐ occasional
- ☐ Maintaining stamina/pace of work
- ☐ Monotony
- ☐ Travel: frequency _____, mode of transportation _____, time of day _____
- ☐ Prolonged work days, overtime
- ☐ On call
- ☐ Repetitive, short cycle work
- ☐ Variety of tasks
- ☐ First responder in emergency situations

Additional Information:

Limitations/Restrictions;

☐ No ☐ Yes

(Specify in Section C)

**Social / Emotional Demands:**

- ☐ Working in isolation
- ☐ Relationship/network building
- ☐ Influencing others
- ☐ Conflict resolution (negotiating, mediating)
- ☐ Working with crisis or emergency situations
- ☐ Teamwork
- ☐ Supervising others
- ☐ Seeking/responding to feedback/constructive criticism
- ☐ Exposure to emotional or confrontational situations
- ☐ Working closely with the public, clients or others (e.g. colleagues, supervisor)

Additional Information:

Limitations/Restrictions;

☐ No ☐ Yes

(Specify in Section C)

**Cognitive / Mental Demands:**

- ☐ Attention to detail
- ☐ Working under specific instructions
- ☐ Attaining precise limits/standards
- ☐ Multitasking
- ☐ Problem solving, decision making
- ☐ Adaptability
- ☐ Sound judgement
- ☐ Handling firearms
- ☐ Continuous alertness, sustained concentration/focus
- ☐ Self-supervision/autonomy
- ☐ Retention of information
- ☐ Organizational ability, time management
- ☐ Initiative
- ☐ Analytical thinking
- ☐ Effective written communication
- ☐ Handling heavy machinery or equipment

Additional Information:

Limitations/Restrictions;

☐ No ☐ Yes

(Specify in Section C)

**Supervisor's Signature:** _____ **Date:**_____

## Section C – Limitations / restrictions (To be completed by attending Physician or Health Care Practitioner)

☐ **additional pages attached**

**Do not provide medical diagnosis, treatment or medication information**

1) Specify the work limitations noted in Section B.# (eg. Frequency of movements; hours of work)

2) Specify the work restrictions noted in Section B.#

3) Specify any restrictions due to medication(s) that can interfere with the safety of the employee and/or his/her co-workers during any of the preceding work abilities in Section B.

4) The employee may begin duties, in accordance with the limitations and restrictions outlined above, on _____.

## Section D – Signature of physician or health care practitioner

Date to reassess this employee's functional abilities if the employee is currently unable to perform the duties outlined in Section B without limitation or restriction:

_____ (dd/mm/yyyy)

Signature: _____ Date: _____

yyyy / mm / dd

Print Name: _____ Title: _____