**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)

<table>
<thead>
<tr>
<th>Employee Name:</th>
<th>PRI:</th>
<th>Classification:</th>
<th>Branch/Division:</th>
<th>Office/Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

**Date of Injury/Illness**

(yyyy/mm/dd):  

**Injury/illness:**

- 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;
- [Insert value] hours/week

**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)

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
</table>
| B.1) Movements of the spinal column | Lower Back:  
- Bending forward  
- Bending backward  
- Twisting  
- Side bending  
- Limitations/Restrictions;  
- No ☐ Yes ☐
| Upper Back:  
- Bending forward  
- Bending backward  
- Twisting  
- Side bending  
- Limitations/Restrictions;  
- No ☐ Yes ☐
| Neck:  
- Bending forward  
- Looking up  
- Rotation  
- Side bending  
- Limitations/Restrictions;  
- No ☐ Yes ☐
| Additional Information: | | |

#### B.2) SITTING ACTIVITIES

- Desk work (reading, writing) - % of day  
- Meetings - % of day  
- Computer work - % of day  
- Driving - % of day  
- Limitations/Restrictions;  
- No ☐ Yes ☐
| Telephone use ☐ with headset) - % of day  
| Other (e.g. lab work, equipment operation) - % of day  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Additional Information: | | |

#### B.3) Standing activities

- Standing - % of day, or hours/day: on surface  
- Walking - distance, hours/day: on surface  
- Limitations/Restrictions;  
- No ☐ Yes ☐
| Stooping ☐  
| Crouching ☐  
| Squatting ☐  
| Kneeling ☐  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Additional Information: | | |

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

- Lifting from/to floor  
- Lifting from/to shoulder level or above  
- Carrying  
- Pushing  
- Pulling  
| Minimum weight  
- kg or lbs  
| Maximum weight  
- kg or lbs  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Additional Information: | | |

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

- Reaching above shoulder level, below shoulder level, at shoulder level  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Typing ☐ % of day  
| Using Computer Mouse ☐  
| Filing ☐  
| Writing ☐ % of day  
| Fingering ☐  
| Additional Information: | | |

#### B.6) Activities requiring senses

- Touch/feeling  
- Colour vision  
- Near vision  
- Far vision  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Depth perception  
- Smelling  
- Tasting  
| Additional Information: | | |

#### B.7) Physical work environment

- Indoors ☐  
- Open office ☐  
- Closed office ☐  
- Confined space ☐  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Outdoors ☐  
- Unpredictable location(s) ☐  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Exposure to weather, noise ☐  
- Extreme heat, cold ☐  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Moisture ☐  
| Fumes/vapours/dust ☐  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Vibration ☐  
| Scented products ☐  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Explosives ☐  
- Radiation ☐  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Falling objects ☐  
- Sharp objects ☐  
- High, exposed places ☐  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Intermittent noise ☐  
| Continuous noise ☐  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Physical violence ☐  
| Infectious exposure ☐  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Biological/chemical contaminants ☐  
| Handling of firearms ☐  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Handling heavy machinery or equipment ☐  

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

**Potential Hazards:**  
- Sustained posture  
- Awkward posture  
| Limitations/Restrictions;  
- No ☐ Yes ☐
| Repeating movements ☐  
| Other ☐  

**Additional Information:**

- Germs, bacteria, fungi, or other biological agents ☐  
- Heat, cold ☐  
- Extreme noise ☐  
- Chemical agents ☐  
- Vibration ☐  
- Other ☐  

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**Note:** Please ensure all sections are completed accurately to provide a comprehensive understanding of the employee’s physical abilities and the work environment.
### B.8) Non-physical work-related capacities

#### Schedule Demands:
- Following a schedule, maintaining attendance/punctuality
- On call
- Prolonged work days, overtime
- Shift work, rotating
- Repetitive, short cycle work
- Deadlines: frequent, or occasional
- Variety of tasks
- Travel: frequency __________, mode of transportation __________, time of day __________

Additional Information:

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

Additional Information:

#### Cognitive / Mental Demands:
- Attention to detail
- Continuous alertness, sustained concentration/focus
- Working under specific instructions
- Self-supervision/autonomy
- Multitasking
- Retention of information
- Problem solving, decision making
- Initiative
- Adaptability
- Analytical thinking
- Sound judgement
- Effective written communication
- Handling firearms
- Handling heavy machinery or equipment

Additional Information:

#### Limitations/Restrictions:
- No
- Yes

(Specify in Section C)

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

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 ________________.

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**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: ____________________________

Print Name: ____________________________ Title: ____________________________ yyyy / mm / dd