Good Spirit
SCHOOL DIVISION

Form 460-1

MEDICAL FUNCTIONAL ABILITIES LONG FORM

Employee Authorization

I consent to the release of the following information to my employer. The following information is required to allow my employer to assist me in returning to work or assisting in a work accommodation as required.

Employee Name _____ Position _____

Signature _____ Date _____

Instructions:

Good Spirit School Division has a duty to accommodate the medical needs of our employees. We must also consider what might pose a danger to the health or safety of the employee or the safety and well-being required for our students or others in the workplace. To initiate a request for reasonable accommodations and/or extended leaves, employees must provide current documentation of a disability.

As the employee's physician or health care provider, you are asked to fully complete all sections of this form. Additional information can be attached if necessary. The information collected will help ensure a safe and successful return to work plan for our employees.

Please complete the attached form and return it to our office as soon as possible. If you have any questions please do not hesitate to contact the Human Resources Department at hr@gssd.ca or (306) 786-4774.

PLEASE DO NOT PROVIDE A DIAGNOSIS OF THE PATIENT'S MEDICAL CONDITION

1. Date of last attendance on patient: _____

   Date of next clinical reassessment: _____

2. Has the patient been referred to a specialist who would have relevant information concerning the issues discussed in this report?

   Yes ☐ No ☐

3. In your opinion is the patient fit for regular duties as outlined in the attached job description?

   Yes ☐ No ☐

4. Is this patient absent from work due to a medical condition which has prevented him or her from performing <u>all of the material and substantial duties of their job</u> in accordance with their job description?

   Yes ☐ No ☐

5. Is the patient following a plan of treatment?

   Yes ☐ No ☐

6. What is the patient's prognosis?

7. What is the estimated date of recovery?

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8. Is *the patient* currently on a course of treatment that involves prescription drugs or over-the-counter medications that carry any warnings or precautions that may be relevant to them in the performance of his/her duties or which could affect the safety of the patient or others?

   Yes ☐ No ☐

   If **<u>"Yes"</u>,** please describe:

9. Since your initial assessment, has the condition: improved? ☐ worsened? ☐
   Describe:

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10. Physical Abilities Assessment Checklist for the patient:

Activity	Work Levels	List Restrictions (Please be clear and specific)	Duration (days, weeks)
Sitting	☐ no restrictions		
Standing	☐ no restrictions		
Walking	☐ no restrictions		
Climbing stairs / Ladder	☐ no restrictions		
Lifting Floor to Waist	☐ no restrictions		
Lifting Waist to Shoulder	☐ no restrictions		
Reaching below shoulder height	☐ no restrictions		
Reaching above shoulder height	☐ no restrictions		
Range of Motion (LT/RT arm)	☐ no restrictions		
Kneeling	☐ no restrictions		
Balancing	☐ no restrictions		
Carrying	☐ no restrictions		
Pushing/Pulling	☐ no restrictions		
Twisting/Bending	☐ no restrictions		
Driving	☐ no restrictions		
Physical stamina/fatigue	☐ no restrictions		
Able to work outside	☐ no restrictions		
Environmental factors	☐ no restrictions		
Hours of Work	☐ no restrictions		
Other	☐ no restrictions		

Assistive Devices Utilized or Advised (canes, wheelchairs, physical bracing, reacher)

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11. Cognitive Abilities Assessment Checklist for the patient:

Activity	Work Levels	List Restrictions (Please be clear and specific)	Duration (days, weeks)
Ability to concentrate or focus attention	☐ no restrictions		
Ability to recall instructions and detail	☐ no restrictions		
Ability to organize daily activities	☐ no restrictions		
Ability to tolerate deadline pressures	☐ no restrictions		
Ability to multi-task	☐ no restrictions		
Ability to manage high volume work load	☐ no restrictions		
Ability to problem-solve simple tasks	☐ no restrictions		
Ability to problem-solve complex tasks	☐ no restrictions		
Ability to make decisions independently	☐ no restrictions		
Ability to complete tasks with minimal supervision	☐ no restrictions		
Ability to work alone	☐ no restrictions		
Ability to work in a group setting	☐ no restrictions		
Ability to supervise others	☐ no restrictions		
Ability to manage confrontational situations	☐ no restrictions		
Ability to deal with members of the public	☐ no restrictions		

Date: _____

Physician's Name/Address: _____

Physician's Phone Number: _____

Physician's Signature: _____