# Non-Occupational Functional Abilities Form

*We are committed to supporting ill and injured employees in their recovery and a safe, timely return to work. We ask that you to complete the questions below to assist us in returning the employee back to work and/or accommodating their disability as soon as possible.*
*Please complete and return the form to the worker and send a copy via fax to ____________________attention ____________________as soon as possible.*

Employee Name: ______________________ DOB: ______________________

Date Eligible to Return to Work: ______________________

*The following information should be completed by the health professional*

Date of examination on which report is based ______________________

Area of Injury: ______________________

Rehabilitation Required? Yes ☐ No ☐

Complete Recovery Expected? Yes ☐ No ☐

Recommendations for Work Hours Full-Time Hours ☐ Modified Hours ☐ Graduated Hours ☐

Walking: Short Distances Only ☐ Other ☐ ______________________

Standing: Less than 30 mins ☐ Other ☐ ______________________

Sitting: Less than 60 mins ☐ Other ☐ ______________________

Lifting floor to waist: Less than 5kg ☐ 5-10kg ☐ Other ☐ ______________________

Lifting waist to shoulder: Less than 5kg ☐ 5-10kg ☐ Other ☐ ______________________

Limited Ability to: Hold Objects ☐ Grip ☐ Type ☐ Write ☐ Other ☐ ______________________

Limitations:

Bending or Twisting of ______________________

Repetitive Movement of ______________________

Above Shoulder Activity ______________________

Below Shoulder Activity ______________________

Environmental Exposure to ______________________

Chemical Exposure to ______________________

Operating motorized equipement ______________________

(Please Specify Duration of Driving) ______________________

Restrictions related to medications ______________________

Exposure to Vibration High Frequency ☐ Low Frequency ☐

Limit Physical Exertion to Mild ☐ Moderate ☐ Full ☐

If the Employee is totally disabled for duty, please give a brief report and prognosis

______________________

______________________

*The Patient has agreed to the release of this medical information*

______________________ ______________________
Signature of Patient/Employee Date

Health Professional's Name (print) ______________________ Occupation ______________________

Date of the Next Appointment ______________________

Full Address: ______________________

Telephone # Signature

SAMPLE