

FUNCTIONAL ACCOMMODATION FORM

Employee's Name (please print): _____ Date of Birth: _____

PART I - Information will not be released by Rehabilitation Services without signed authorization

Date of Assessment: _____ Is the claim being submitted to the Workplace Safety & Insurance Board? Yes No

Reason for Absence/Modifications:

Treatment: Rehabilitation Required? Yes No

Treatment Plan (including medications): _____

Summarize Response to Treatment: _____

Barriers for Return to Work: _____

Complete Recovery Expected? Yes No Unknown

PART II - May be copied to individuals who are assisting with accommodation process

Estimated Return to Work Date (if currently absent): _____ Date of Next Medical Review: _____

Fit (full hours & duties) Unfit Fit with Precautions

Current Functional Limitations: Estimated Duration of Limitations: _____ Permanent

<u>Function</u>		<u>Comments</u>
Walk Continuously	Limit to _____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Stand Continuously	Limit to _____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Sit Continuously	Limit to _____ <input type="checkbox"/> Minutes <input type="checkbox"/> Hours	_____
Grip <input type="checkbox"/> Pinch <input type="checkbox"/>	Limit to _____	_____
Push/Pull	Limit to _____ Kg	_____
Bend/Twist (of: _____)	Limit to _____ Kg	_____
Lift/Carry: <input type="checkbox"/> Floor to Waist	Limit to _____ Kg	_____
<input type="checkbox"/> Waist to Shoulder	Limit to _____ Kg	_____
<input type="checkbox"/> Above Shoulder	Limit to _____ Kg	_____
Climb: Ladder <input type="checkbox"/> Stairs <input type="checkbox"/>	Limit to _____	_____
Restricted Use of Limbs?	Specify: _____	_____

	<u>Level of Limitation</u>	<u>Comments</u>
Understanding/Memory	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____
Attention to Detail/Concentration	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____
Need to work co-operatively with others	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____
Adaptation/Ability to Accommodate Change	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____
Responsibility/Accountability/Decision-making	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____
Communication/Comprehension	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____
Performance of Multiple Tasks	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____
Ability to Work to Deadlines	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____
Exposure to Environmental Stimuli/Distraction	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____
Stamina/Energy	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____
Operation of Motorized Equipment	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____
Other: _____	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	_____

Recommended for work hours: Full-Time Modified Hours (please specify): _____

(Treating Practitioner's Name - Please Print)

(Signature)

(Date)