TORONTO

Return to Work Information

Section A: To be completed by the employer ☐ **Initial Form** ☐ **Follow-up Form**

Social Insurance No:	WSIB Claim No (if available):	Employee No:
Worker's Last Name:	First Name:	Home Telephone:
Home Address:		Postal Code:
Date of Accident/Onset of Illness:	Area of injury(if applicable):	
Job at time of Accident/Illness:		Physical Demands Analysis enclosed ☐ Yes ☐ No
Department/Division:	Supervisor:	Telephone:
Work Address:		Work Telephone:

Section B: To be completed by the treating health professional and returned to the worker

Nature of Injury/Illness:	☐ medical illness ☐ injury (please indicate)	
Estimated Recovery Time:		Is Complete Recovery Expected? ☐ Yes ☐ No
Please specify further treatment required, if any:		

Ability to Return to Work (Check only one)

☐ Able to return to work immediately without restrictions		
☐ Able to return to modified duties. Modified duties are recommended for:	Days, or	Weeks
☐ Unable to participate in any work, including modified duties for:	Days, or	Weeks

If Modified Duties Are Required, Please Check any Specific Medical Restrictions Necessary.

LIFTING (floor to knuckle)	☐ No loads > 20 kg	☐ No loads > 10 kg	☐ Occasional lifting only
LIFTING (knuckle to chest)	☐ No loads > 20 kg	☐ No loads > 10 kg	☐ Occasional lifting only
LIFTING (above chest)	☐ No loads > 20 kg	☐ No loads > 10 kg	☐ Occasional lifting only
CARRYING	☐ No loads > 20 kg	☐ No loads > 10 kg	☐ Occasional carrying only
PUSHING/PULLING	☐ No heavy pushing/pulling	☐ Occasional pushing/pulling	☐ Avoid Pushing/pulling
HAND FUNCTION	☐ Avoid repetitive hand motion	☐ No strong gripping	☐ Avoid gripping
REACHING	☐ No prolonged overhead reaching	☐ No overhead reaching	☐ Avoid any reaching
SITTING	☐ No prolonged sitting		
STANDING	☐ No prolonged standing	☐ Avoid standing	
WALKING	☐ No prolonged walking	☐ Avoid uneven ground	☐ Avoid walking
CLIMBING (stairs/ladders)	☐ Occasional climbing only	☐ No ladder climbing	
BENDING	☐ No prolonged bending	☐ Occasional bending only	☐ Avoid bending
CROUCHING/KNEELING	☐ No prolonged crouching/kneeling	☐ Occasional crouching/kneeling only	☐ Avoid crouching/kneeling

Are there any contraindications to the testing process if the City's disability management staff recommend this employee for functional abilities testing?

☐ Yes ☐ No

Comments/Specific Limitations: Please describe any additional related medical restrictions pertaining to – effects of medication, driving vehicles or operating equipment, physical exertion, vibration, work environment, work hours.

Health professional's name and title:		
Address:		Postal Code:
Telephone:	Signature:	Date:
Examination date:	Next appointment date:	

Section C: Worker Consent (to be completed by the worker)

I authorize the health professional involved with my treatment to provide me, my employer, and the Workplace Safety and Insurance Board (if applicable) this completed form containing information about any limitations/restrictions affecting my ability to return to work.

Signature: Date: