

Section A: To be completed by the Worker or Employer

Worker Information		
WSIB Claim Number (if applicable)		Employee Number
First Name	Last Name	Home Telephone Number
Home Address (Street Number, Street Name, Suite/Unit Number, City/Town, Province, Postal Code)		
Injury/Onset of Illness Date (yyyy-mm-dd)		Area of Injury (if applicable)
Job at time of Injury/Illness		
Division	Work Address (Street Number, Street Name, Suite/Unit Number, City/Town, Province, Postal Code)	
Supervisor Name (First, Last)	Work Telephone Number	Alternate Telephone Number

Section B: To be completed by Health Professional and returned to the Worker

Please check one: Initial Form Follow-Up Form

Nature of Injury/Illness: <input type="checkbox"/> medical illness <input type="checkbox"/> injury, please indicate:	
Estimated Recovery Time:	Is Complete Recovery Expected: <input type="checkbox"/> Yes <input type="checkbox"/> No
Please specify further treatment required, if any:	

Ability 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 the Worker has any functional limitations, please check the necessary precaution(s)

Strength Demands	Abilities	Abilities	Abilities
<input type="checkbox"/> Lifting floor to knuckle	<input type="checkbox"/> No loads >20 kg	<input type="checkbox"/> No loads >10 kg	<input type="checkbox"/> Occasional lifting only
<input type="checkbox"/> Lifting knuckle to chest	<input type="checkbox"/> No loads >20 kg	<input type="checkbox"/> No loads >10 kg	<input type="checkbox"/> Occasional lifting only
<input type="checkbox"/> Lifting above chest	<input type="checkbox"/> No loads >20 kg	<input type="checkbox"/> No loads >10 kg	<input type="checkbox"/> Occasional lifting only
<input type="checkbox"/> Carrying	<input type="checkbox"/> No loads >20 kg	<input type="checkbox"/> No loads >10 kg	<input type="checkbox"/> Occasional carrying only
<input type="checkbox"/> Pushing/Pulling	<input type="checkbox"/> No heavy pushing/pulling	<input type="checkbox"/> Occasional pushing/pulling	<input type="checkbox"/> Avoid pushing/pulling
<input type="checkbox"/> Hand Function	<input type="checkbox"/> Avoid repetitive hand motion	<input type="checkbox"/> No strong gripping	<input type="checkbox"/> Avoid gripping
<input type="checkbox"/> Reaching	<input type="checkbox"/> No prolonged overhead reaching	<input type="checkbox"/> No overhead reaching	<input type="checkbox"/> Avoid any reaching
<input type="checkbox"/> Sitting	<input type="checkbox"/> No prolonged sitting		
<input type="checkbox"/> Standing	<input type="checkbox"/> No prolonged standing	<input type="checkbox"/> Avoid standing	
<input type="checkbox"/> Walking	<input type="checkbox"/> No prolonged walking	<input type="checkbox"/> Avoid uneven ground	<input type="checkbox"/> Avoid walking
<input type="checkbox"/> Climbing stairs/ladders	<input type="checkbox"/> Occasional climbing only	<input type="checkbox"/> No ladder climbing	
<input type="checkbox"/> Stooping/Bending	<input type="checkbox"/> No prolonged stooping/bending	<input type="checkbox"/> Occasional stooping/bending only	<input type="checkbox"/> Avoid stooping/bending
<input type="checkbox"/> Crouching/Kneeling	<input type="checkbox"/> No prolonged crouching/kneeling	<input type="checkbox"/> Occasional crouching/kneeling only	<input type="checkbox"/> Avoid crouching/kneeling

Return to Work Information

All City of Toronto Employees (except Local 79)

Behavioural/Cognitive Restrictions and/or Limitations

Complete this section if the medical condition has resulted in a restriction/limitation. Check all that apply

Yes, see below Not Applicable

Behavioural/Cognitive Demands			
<input type="checkbox"/> Ability for self-supervision	<input type="checkbox"/> Performance of multiple tasks	<input type="checkbox"/> Tolerance of confrontational situations	<input type="checkbox"/> Numeric skills
<input type="checkbox"/> Ability to supervise others	<input type="checkbox"/> Tolerance to distracting stimuli	<input type="checkbox"/> Responsibility and accountability	<input type="checkbox"/> Communication
<input type="checkbox"/> Ability to tolerate time pressures	<input type="checkbox"/> Ability to work cooperatively	<input type="checkbox"/> Reading literacy	<input type="checkbox"/> Memory
<input type="checkbox"/> Ability to concentrate and attend to detail	<input type="checkbox"/> Tolerance of emotional situations	<input type="checkbox"/> Writing literacy	<input type="checkbox"/> Computer literacy

Are there any contraindications to the testing process if the City's Disability Management staff recommend this employee for functional testing?

Yes No

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

Health Professional Information (PLEASE PRINT):

Name (First, Last)		Position Title	
Business Address (Street Number, Street Name, Suite/Unit Number, City/Town, Province, Postal Code)			
Business Telephone Number		Date (yyyy-mm-dd)	
Exam Date (yyyy-mm-dd)	Next Appointment Date (yyyy-mm-dd)		
Health Professional Signature			

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.

Worker Signature

Date (yyyy-mm-dd)