FUNCTIONAL ABILITIES FORM

Dear Health Care Practitioner:

Our employee, _____ has sustained an injury/illness. We respectfully request your assistance in identifying their capabilities/restrictions. Labatt is committed to assisting our employees with a safe and timely return to work using appropriate modified work assignments to facilitate their recovery.

Employee's Signature: By signing below, I am authorizing any health professional who treats me to provide me, my employer and Manulife Insurance (when applicable) with information about my functional abilities, as documented on this Labatt's "Functional Abilities" form.

Signature: _____ Date: _____

Examination Date: _____ Time: _____ ☐ a.m. ☐ p.m.

The employee:

☐ Is capable of returning to work with no restrictions.

☐ Is capable of returning to work with restrictions as noted below. (Please complete Sections A, B & C)

☐ Is physically unable to return to work at this time. (Please complete Section C)

Section A Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in Section B

Walking:	Standing:	Sitting:	Lifting from floor to waist:
☐ Full Abilities ☐ Up to 100 metres ☐ 100 – 200 metres ☐ Other (please specify)	☐ Full Abilities ☐ Up to 15 minutes ☐ 15 – 30 minutes ☐ Other (please specify)	☐ Full Abilities ☐ Up to 30 minutes ☐ 30 minutes to 1 hour ☐ Other (please specify)	☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 – 10 kilograms ☐ Other (please specify)
Lifting from waist to shoulder:	**Stair climbing:**	**Ladder climbing:**	**Travel to work:**
☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 – 10 kilograms ☐ Other (please specify)	☐ Full Abilities ☐ Up to 5 steps ☐ 5 – 10 steps ☐ Other (please specify)	☐ Full Abilities ☐ 1 – 3 steps ☐ 4 – 6 steps ☐ Other (please specify)	Ability to use Public Transit: ☐ Yes ☐ No Ability to Drive a Vehicle: ☐ Yes ☐ No

2. Please indicate **Restrictions** that apply. Include additional details in Section B

☐ Bending/Twisting Repetitive Movement of (please specify)	☐ Work at or above shoulder activity:	☐ Limited pushing/pulling with: ☐ Left Arm ☐ Right Arm	☐ Limited use of hand(s): Left / Right ☐ Gripping ☐ ☐ Pinching ☐ ☐ : Other (please specify) ☐
☐ Environmental exposure to: (i.e. heat, cold, noise or scents) ☐ Chemical Exposure to:	☐ Operating motorized equipment (i.e. forklift):	☐ Overtime **NOT** restricted: (may work more than 40 hours/week) ☐ Overtime restricted while on modified work and/or modified hours	☐ Exposure to vibration: ☐ Whole body ☐ Hand/Arm

Section B Additional Comments on Abilities and/or Restrictions

From the date of this assessment, the above will apply for approximately:

☐ 1 – 2 Days ☐ 3 – 7 Days ☐ 8 – 14 Days ☐ 14 + days

Have you discussed return to work with your patient?

☐ Yes ☐ No

Recommendations for work hours and start date:

☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours

Start Date: d d m m y y y y

Section C Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions** ▶ d d m m y y y y

Treatment Plan:

Estimated date for return to regular job duties:

Thank you for your assistance in attending to our employee.

Health Care Practitioner's Signature

Date:

Health Care Practitioner's Name (Please Print)

Health Care Practitioner's Address and Contact Information (Stamp if available)