Functional Information (Form # 2)

Request for Functional Information of presenting illness/injury

Human Resources Division
The City of Corner Brook
P.O Box 1080
Corner Brook, NL, A2H 6E1
Physic 627, 1527, Confidential Fox 627

Phone: 637-1527, Confidential Fax 637-1543

The intent of this form is to facilitate a safe and healthy return to work.

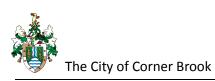
The City of Corner Brook will require this physician's report (form #2) to be completed after five (5) consecutive days of absence from work due to medical reasons.

TO THE EMPLOYEE

The City of Corner Brook aims to assist employees in their rehabilitation and return to full health and employment. Part of the process is to obtain information about your current abilities from your physician as it relates to your illness/injury. To do this we ask that you have your treating physician complete this form. This completed form must be returned to the Human Resources division within 24 hours of your appointment.

The City will reimburse the employee up to the amount of \$50.00 for the cost of completing this form. The employee must pay upfront and provide the receipt to Human Resources as proof of payment.

Section 1 (To be completed by EMPLOYEE)	
Employee Name:	Date of Hire:
Address:	Telephone (Home):
Work Site: City Hall □ Operational Services Depot □ Fire Department □	Telephone (Work):
Immediate Supervisor:	Telephone (Work):
EMPLOYEE: I authorize my Health Care Provider to disclose functional information related developing a safe return to work plan. The employer will keep this information confidential. It received by the City from my physician and will be made aware of any further requests for me that the City of Corner Brook, as my employer, is only requesting information regarding to my information pertaining to a diagnosis of my illness or injury.	understand that I will receive a copy of any medical information dical information from the City of Corner Brook. I also understand
Employee's Signature:	Date:
Section 2 (To be completed by Physician or Authorized Health Profe	essional)
TO THE PHYSICIAN/AUTHORIZED HEALTH PROFESSIONAL	
 The information shared on this form will be kept private and confidential. Do not provide a diagnosis of the illness/injury, names of medications, or 	traatmant
3. A copy of the individual's job description is enclosed for your reference.	treatment
Does Employee have any significant physical, psychological or mental impairment that co	urrently impairs the employee from returning to unrestricted
duties?	
NO Employee can return to unrestricted work activitiesYES If yes, please answer the following questions.	
If employee currently has a physical impairment, please complete the Physical Capability	y Assessment (included). If the impairment is non physical, please
describe the current limitations the employer should be aware of in the search for sui	
public, shortened work day tolerance). PLEASE DO NOT INCLUDE A DIAGNOSIS.	
Is the physical or psychological impairment: Temporary ORPermanent ORUnsure If the impairme	nt is temporary, how long do you think the impairment will last?
	_ 4-6 weeks 6-8 weeks >3 mths
	return to unrestricted work duties?
within the listed abilities/limitations?	
Is this illness/injury chro	nic? Yes No
When is employee scheduled for his/her next reassessment?	10
How were medical conclusions reached:Diagnostic/Other objective tests OR	Self-Reported OR Both
	<u>.</u>
(Optional) Are there any workplace restrictions that the Employer could address to assis	t in recovery and rehabilitation?
Does the City have your permission to contact you by telephone or confidential fax for cla	arification of any information indicated on this form?
YesNo	
Healthcare Provider: The information provided in this document is true	and based on my examination of the nation
·	Date:
Signature:	Date.
Name (please print):	
Mailing Address:	
Telephone Number:	Confidential Fax Number:



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LIFTING	No Restriction	Occasional	Restricted
Sedentary			
Light			
Medium			
Heavy			

ARM USE	No Restriction	Occasional	Restricted
Above shoulder			
To the floor			

HAND USE	No Restriction	Occasional	Restricted
Above shoulder			
To the floor			
Gripping			

STANDING	No Restriction	Occasional	Restricted
1 hr – 2 hr			
2 hr – 4 hr			
4 hr – 6 hr			

CLIMBING	No Restriction	Occasional	Restricted
Stairs			
Ladders			

Date: _

Employee Name:	
Date of Assessment:	

CARRYING	No Restriction	Occasional	Restricted
Sedentary			
Light			
Medium			
Heavy			

SHOULDER MOVEMENTS	No Restriction	Occasi onal	Restricted
1 hr – 2 hr			
2 hr – 4 hr			
6 hr – 8 hr			

BENDING	No Restriction	Occasional	Restricted
To a desk			
To the floor			

WALKING	No Restriction	Occasional	Restricted
Up to 10 minutes			
10 – 30 minutes			
30 – 60 minutes			

SITTING	No Restriction	Occasional	Restricted
1 hr – 2 hr			
2 hr – 4 hr			
6 hr – 8 hr			

PUSHING	No Restriction	Occasional	Restricted
Light			
Medium			
Heavy			

PULLING	No Restriction	Occasional	Restricted
Light			
Medium			
Heavy			

VOICE/	No	Occasional	Constant
SPEECH	Difficulty	Difficulty	Difficulty
HEARING	No	Occasional	Constant
	Difficulty	Difficulty	Difficulty
VISION	No	Occasional	Constant
	Difficulty	Difficulty	Difficulty
WRITING	No	Occasional	Constant
	Difficulty	Difficulty	Difficulty

		r ieuse circie	one assessment option, where appro	priate	
CONCENTRATION	No Restriction	Limited: Tasks will take longer	Limited: Tasks should require minimal concentration	Other (specify):	
JUDGEMENT	No Restriction	Limited: Decisions will take longer	Limited: Tasks should not require decisions to be made	Other (specify):	
MEMORY	No Restriction	Limited: Tasks will be forgotten and may take longer to recall	Limited: Tasks should be written down	Other (specify):	
MULTIPLE TASKS		No Restriction	Limited: Tasks should be handled one at a time	Other (specify)	
PUBLIC CONTACT	No Restriction	Limited: Exposure should be minimal, small groups	Limited: No contact	Other (specify):	
PROVIDING SUPERVISION	No Restriction	Limited: Occasional supervising	Limited: No supervising	Other (specify):	
TRAVEL TO WORK	No Restriction	Not able to drive	Able to use public transit	Not able to use public transit	
POTENTIAL SIDE EFFECTS FROM MEDICATIONS Please specify, but do not include names of medications					
ENVIRONMENTAL EXPOSURE (eg. heat, cold, noise, etc) Please specify					
OTHER INFORMATIO	N				
From the date of this assessment, the above will apply for approximately1-2 days3-7 days8-14 days14+ daysOther:					
Recommended working hours:Regular full-time hoursModified hoursGraduated hours RETURN DATE:					
If the patient is unable to work, can they attend check-in meetings with a representative of the City's Human Resources division?YesNo If "No", why?					
Medical Providers Signature:					
Medical Providers Na	me:				

Medical

Office Stamp

(please print)