The City of Corner Brook

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
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 to my current illness or injury to my Employer for the purpose of developing a safe return to work plan. The employer will keep this information confidential. I understand that I will receive a copy of any medical information received by the City from my physician and will be made aware of any further requests for medical information from the City of Corner Brook. I also understand that the City of Corner Brook, as my employer, is only requesting information regarding to my functional abilities and/or limitations. They are not requesting any information pertaining to a diagnosis of my illness or injury.

Employee's Signature:	**Date:**

Section 2 (To be completed by Physician or Authorized Health Professional)

TO THE PHYSICIAN/AUTHORIZED HEALTH PROFESSIONAL

1. The information shared on this form will be kept private and confidential.
2. Do not provide a diagnosis of the illness/injury, names of medications, or treatment
3. A copy of the individual's job description is enclosed for your reference.

Does Employee have any significant physical, psychological or mental impairment that currently impairs the employee from returning to unrestricted duties?
_____ NO Employee can return to unrestricted work activities.
_____ YES If yes, please answer the following questions.

If employee currently has a physical impairment, please complete the Physical Capability Assessment (included). If the impairment is non physical, please describe the current limitations the employer should be aware of in the search for suitable transitional duties (Example: inability to interact with the public, shortened work day tolerance). PLEASE DO NOT INCLUDE A DIAGNOSIS.

Is the physical or psychological impairment: _____Temporary OR _____ Permanent OR_____Unsure	**If the impairment is temporary, how long do you think the impairment will last? ___ 2-4 weeks __ 4-6 weeks __ 6-8 weeks __ >3 mths**
When can employee return to transitional/restricted duties within the listed abilities/limitations?	**When do you anticipate a return to unrestricted work duties?**
	Is this illness/injury chronic? _____Yes ____ No

When is employee scheduled for his/her next reassessment?

How were medical conclusions reached: _____Diagnostic/Other objective tests OR _____ Self-Reported OR_____Both

(Optional) Are there any workplace restrictions that the Employer could address to assist in recovery and rehabilitation?

Does the City have your permission to contact you by telephone or confidential fax for clarification of any information indicated on this form?
____Yes ____No

Healthcare Provider: The information provided in this document is true and based on my examination of the patient.

Signature:	**Date:**
Name (please print):	
Mailing Address:	
Telephone Number:	**Confidential Fax Number:**

Physical Capability Assessment of presenting illness/injury (to be completed by medical provider)

The City of Corner Brook

Return to:
Human Resources Division
The City of Corner Brook
P.O Box 1080
Corner Brook, NL, A2H 6E1
Phone: 637-1527, Confidential Fax 637-1543

Employee Name: _____

Date of Assessment: _____

LIFTING	No Restriction	Occasional	Restricted
Sedentary			
Light			
Medium			
Heavy			

CARRYING	No Restriction	Occasional	Restricted
Sedentary			
Light			
Medium			
Heavy			

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

ARM USE	No Restriction	Occasional	Restricted
Above shoulder			
To the floor			

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

PUSHING	No Restriction	Occasional	Restricted
Light			
Medium			
Heavy			

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

BENDING	No Restriction	Occasional	Restricted
To a desk			
To the floor			

PULLING	No Restriction	Occasional	Restricted
Light			
Medium			
Heavy			

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

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

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

CLIMBING	No Restriction	Occasional	Restricted
Stairs			
Ladders			

Please circle one assessment option, where appropriate

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 INFORMATION

From the date of this assessment, the above will apply for approximately
__1-2 days __3-7 days __8-14 days __14+ days __Other:

Recommended working hours: ___Regular full-time hours ___Modified hours ___Graduated 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? __Yes __No
If "No", why?

Medical Providers Signature: _____

Medical Providers Name: _____
(please print)

Date: _____

Medical Office Stamp