ABILITIES FORM

Clear Form

WORKER INFORMATION

Name:		Location:	

Date of Birth:		Accident/Illness Date:	Pre-existing Condition: Yes No
Nature of Injury/Illness:			Occupational: Yes No

The worker authorizes the employer to contact the health professional and agrees to the release of this information. The employer will be responsible for payment to the health professional for information on this report.

____
Employee Signature – authorizing release of information to ADSB

DESCRIPTION OF NORMAL JOB DUTIES AND REQUIREMENT

Job Title:

HEALTH PROFESSIONAL'S INFORMATION

Name:

Phone:

Signature: **Date:**

HEALTH PROFESSIONAL COMMENTS:

NOTE: By providing the information requested on this report, you will assist the organization in planning for the worker's early vocational rehabilitation. To ensure that appropriate rehabilitative measures are instituted, modified work and/or assistive devices will be made available to suit the current temporary disability. By indicating the appropriate precautions, with limitations, a return to work plan may be developed depending on accommodations required. The work offered will be productive, will not aggravate the worker's injury and will not pose additional hazards to the worker or co-workers.

* SECTION A – Unable to Perform Any Duties

Estimated time before participation in modified work program.

_____ Days OR _____ Weeks

* SECTION B – Physical Precautions

The worker may return to modified work with the following precautions:

No lifting over ____ kgs

No prolonged sitting

No prolonged walking
No prolonged standing
No excessive pushing
No excessive pulling
No physical restraining
No reaching above shoulder
No reaching below shoulder
No mopping – dry
No mopping – wet

No prolonged carrying
No stair climbing
No ladder climbing
No repetitive kneeling
No repetitive twisting
No repetitive bending
Other _____________
____

Duration of precautions: _____ days OR _____ weeks

* SECTION C – Progressive Return

The worker may return to modified work with the following modifications:

Shorter day: _____ hours per day and _____ days per week

Progressive return to work:

Start at: ______ hours per day and ______ days per week.

Progressing at: _____ hours per day and ____ days per week.

Duration: ______ weeks

* SECTION D – Start Date

The worker is able to start the above program on:

Date: ____________________________

* SECTION E – Return to Regular Duties

The worker may return to regular duties on:

Date: ____________________________

SECTION B – **Mental/Nervous Impairment** (If applicable complete attached page 2)

ABILITIES FORM

Section B – Mental/Nervous Impairment – cont'd
Employee is able to function under stress and engage in interpersonal relations (no limitations)
Employee is able to function in most stress situations and engage in most interpersonal relations (slight limitations as listed below)
Employee is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations as listed below)
Employee is unable to engage in stress situations or engage in interpersonal relations (marked limitations as listed below)
Employee has significant loss of psychological, physiological, personal and social adjustment (severe limitations as listed below)
Limitations:
Suggested work modifications required to accommodate limitations: