Functional Abilities Form

This form, when completed, is used to enable an employer to accommodate an ill or injured employee to remain at, or if absence is unavoidable, to return to work as soon as they are safely able to do so. It is an example of a document that reflects best practices in obtaining information from health care practitioners in case of employee illness or injury, suitable for use anywhere in the federal public service.

Download the Physician Letter: Functional Abilities Form

Section A – Employee's information (To be completed by the employee's supervisor)

Employee Name:

Personal Record Identifier (PRI):

Classification:

Branch/Division:

Office/Location:

Date of Injury/Illness: (yyyy/mm/dd)

Injury/Illness is:

- Work Related
- Non-Work Related
- First Occurrence, or
- Recurrence

Absence commenced: (yyyy/mm/dd)

Job title/occupation:

Employee's regular work hours:

- Number of hours/day:
- Number of hours/week:
- Seasonal: (yyyy/mm/dd) to (yyyy/mm/dd):

Supervisor’s Name:

Supervisor’s Tel #

Section B – Required work capacities (To be completed by the employee’s supervisor)

The employee’s regular work duties require the following physical and/or non-physical capacities. Please note: ratings are approximate. (SECTION C – Limitations/Restrictions to be completed by attending Medical Practitioner or Treating Therapist)

B.1) Movements of the spinal column

Lower Back:

- Bending forward
- Bending backward
- Twisting
- Side bending

Upper Back:

- Bending forward
- Bending backward
- Twisting
- Side bending

Neck:

- Bending forward
- Looking up
- Rotation
- Side bending

Additional Information on movements of the spinal column:

Limitations/Restrictions; (To be completed by treating physician or health care practitioner)

- No
- Yes, Specify in Section C

B.2) Sitting activities

- Desk work (reading, writing) – [Insert value] % of day
- Meetings – [Insert value] % of day
- Computer work – [Insert value] % of day
- Driving – [Insert value] % of day
- Telephone use (with headset) – [Insert value] % of day
- Other (e.g. lab work, equipment operation) – [Insert value] % of day

Additional Information on sitting activities:

Limitations/Restrictions; (To be completed by treating physician or health care practitioner)

- No
- Yes, Specify in Section C

B.3) Standing activities

- Standing – [insert value] % of day, or [insert value] hours/day: on [insert type of surface]
- Walking – [insert value] distance, [insert value] hours per day: on [insert type of surface]
- Balancing -activities requiring balancing:
- Stooping
- Crouching
- Squatting
- Kneeling
- Crawling
- Climbing (e.g., stairs, step ladders) – [insert type]
- Operating general office equipment (e.g., printer, photocopier, paper cutter)

Additional Information on standing activities:

Limitations/Restrictions; (To be completed by treating physician or health care practitioner)

- No
- Yes, Specify in Section C

B.4) Lifting / carrying / pushing / pulling

- Lifting from/to floor:
  Minimum weight [insert value] kg or [insert value] lbs; Maximum weight [insert value] kg or [insert value] lbs
- Lifting from/to shoulder level or above:
  Minimum weight [insert value] kg or [insert value] lbs; Maximum weight [insert value] kg or [insert value] lbs
- Carrying:
  Minimum weight [insert value] kg or [insert value] lbs; Maximum weight [insert value] kg or [insert value] lbs
- Pushing:
  Minimum weight [insert value] kg or [insert value] lbs; Maximum weight[insert value] kg or [insert value] lbs
- Pulling:
  Minimum weight [insert value] kg or [insert value] lbs; Maximum weight[insert value] kg or [insert value] lbs

Additional Information on lifting / carrying / pushing / pulling:

Limitations/Restrictions; (To be completed by treating physician or health care practitioner)

- No
- Yes, Specify in Section C

B.5) Working with shoulders / elbows / wrists / hands / fingers

- Reaching:
    - above shoulder level,
    - below shoulder level,
    - at shoulder level
- Handling:
    - fine objects,
    - tools/objects requiring strong hand grip,
    - vibrating tools/objects
- Typing – [insert value] % of day
- Using Computer Mouse,
- Filing
- Writing – [insert value] % of day
- Fingering

Additional Information on working with shoulders / elbows / wrists / hands / fingers:

Limitations/Restrictions; (To be completed by treating physician or health care practitioner)

- No
- Yes, Specify in Section C

B.6) Activities requiring senses

- Touch/feeling
- Speaking
- Hearing
- Colour vision
- Near vision
- Far vision
- Depth perception
- Smelling
- Tasting
- Driving
- Viewing computer screen – [insert value] % of day

Additional Information on activities requiring senses:

Limitations/Restrictions; (To be completed by treating physician or health care practitioner)

- No
- Yes, Specify in Section C

B.7) Physical work environment

- Indoors
- Closed office; Open office (e.g. cubicle); confined space
- Outdoors
- Unfamiliar/unpredictable location(s) – [insert value] % of day
- Exposure to:
    - weather,
    - noise/distracting stimuli

- Extreme:
    - heat,
    - cold
- Moisture (wet/humid)
- Dryness
- Fumes/vapours/dust
- Vibration
- Scented products
- Wildlife

Potential Hazards:

- Explosives
- Electric shock
- Radiation ionizing, non-ionizing
- Falling objects
- Sharp objects
- High, exposed places
- Sustained posture
- Intermittent noise
- Continuous noise
- Moving Mechanical Parts
- Awkward posture
- Physical violence
- Infectious exposure
- Waste handling
- Repetitive movements
- Biological/chemical contaminants
- Handling of firearms
- Handling heavy machinery or equipment
- Other: – [insert value]

Describe the type of Personal Protective Equipment used (if required) to protect against the physical work environment hazards:

Limitations/Restrictions; (To be completed by treating physician or health care practitioner)

- No
- Yes, Specify in Section C

B.8) Non-physical work-related capacities

Schedule Demands:

- Following a schedule, maintaining attendance/punctuality
- Prolonged work days, overtime
- Shift work, rotating
- On call
- Deadlines:
    - frequent, or
    - occasional
- Repetitive, short cycle work
- Maintaining stamina/pace of work
- Variety of tasks

- Monotony
- First responder in emergency situations
- Travel: frequency [insert value], mode of transportation [insert value], time of day [insert value]

Additional Information on schedule demands:

Limitations/Restrictions; (To be completed by treating physician or health care practitioner)

- No
- Yes, Specify in Section C

Social / Emotional Demands:

- Working in isolation
- Teamwork
- Relationship/network building
- Supervising others
- Influencing others
- Seeking/responding to feedback/constructive criticism
- Conflict resolution (negotiating, mediating)
- Exposure to emotional or confrontational situations
- Working with crisis or emergency situations
- Working closely with the public, clients or others (e.g. colleagues, supervisor)

Additional Information on social / emotional demands:

Limitations/Restrictions; (To be completed by treating physician or health care practitioner)

- No
- Yes, Specify in Section C

Cognitive / Mental Demands:

- Attention to detail
- Continuous alertness, sustained concentration/focus
- Working under specific instructions
- Self-supervision/autonomy
- Attaining precise limits/standards
- Retention of information
- Multitasking
- Organizational ability, time management
- Problem solving, decision making
- Initiative
- Adaptability
- Analytical thinking
- Sound judgement
- Effective written communication
- Handling firearms
- Handling heavy machinery or equipment

Additional Information on cognitive / mental demands:

Limitations/Restrictions; (To be completed by treating physician or health care practitioner)

- No
- Yes, Specify in Section C

Supervisor’s Signature:

Date:

Section C – Limitations / restrictions (To be completed by attending Physician or Health Care Practitioner)

- **Additional pages attached**

Do not provide medical diagnosis, treatment or medication information

1. Specify the work limitations noted in Section B. (eg. Frequency of movements; hours of work)
2. Specify the work restrictions noted in Section B.
3. Specify any potential restrictions due to medication(s) that can interfere with the safety of the employee and/or his/her co-workers during any of the preceding work
   abilities in Section B.
4. The employee may begin duties, in accordance with the limitations and restrictions outlined above, on (dd/mm/yyyy).

Section D – Signature of physician or health care practitioner

Date to reassess this employee’s functional abilities if the employee is currently unable to perform the duties outlined in Section B without limitation or restriction: (dd/mm/yyyy)

Attending Physician or Health Care Practitioner’s Signature:

Print Name:

Title:

Date: