Abilities, Wellness & Attendance
Human Resources Support Services
Tel: 905.890.1010 Ext. 2762 or 2428
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peel District School Board

ABILITIES FORM

A. The following should be completed by the patient to provide his/her information and consent.

Please select one: ☐ Workplace Injury/Illness ☐ Other (Non-occupational)

Last Name:	First Name:	
Address:	Telephone Number:	
Date of Birth (dd/mm/yy):	Employee ID:	WSIB Claim #: *(If applicable)*

I authorize the health care professional to release the information requested on this Abilities Form to the Peel District School Board as it relates to my current absence from work or needs for accommodation at work.

Patient's Signature _____ Date (dd/mm/yy) _____

B. The following should be completed by the Health Practitioner to identify the patient's overall abilities and restrictions.

Date of Assessment: (dd/mm/yy) _____

Area of injury/illness: _____

Please check one:

☐ Patient is capable of returning to work with **no restrictions**.

☐ Patient is capable of returning to work **with restrictions**. Complete **C to F**.

☐ Patient is physically/psychologically unable to return to work. Complete **C to F**.

C. Physical Abilities: Please indicate abilities that apply.

Walking:
- ☐ Full abilities
- ☐ Up to 100 meters
- ☐ 100 - 200 meters
- ☐ Other (specify) _____

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15-30 minutes
- ☐ Other (specify) _____

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes – 1 hour
- ☐ Other (specify) _____

Lifting floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5-10 kilograms
- ☐ Other (specify) _____

Lifting waist to shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5-10 kilograms
- ☐ Other (specify) _____

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5-10 steps
- ☐ Other (specify) _____

Pushing/pulling:
- ☐ Full abilities
- ☐ Up to 5 kg of force
- ☐ Up to 10 kg of force
- ☐ Other (specify) _____

Travel to work:

Ability to drive car ☐ Yes ☐ No

Ability to use public transit ☐ Yes ☐ No

D. Work Restrictions: Please indicate restrictions that apply.

☐ Bending/twisting repetitive movement of (please specify): _____	☐ Work at or above shoulder activity: _____	☐ Chemical exposure to: _____
☐ Environmental exposure to (e.g. heat, cold, noise, scents): _____	☐ Operating motorized equipment: _____	☐ Potential side effects from medications (do not include names): _____

D. Work Restrictions (continued): Please indicate restrictions that apply.

☐ Stooping	☐ Squatting	☐ Kneeling

E. Cognitive Abilities: Please indicate abilities that apply.

Memory/concentration: ☐ Full abilities ☐ Limited abilities (specify)	**Following directions:** ☐ Full abilities ☐ Limited abilities (specify)	**Making decisions:** ☐ Full abilities ☐ Limited abilities (specify)
Multi-tasking: ☐ Full abilities ☐ Limited abilities (specify)	**Working with others:** ☐ Full abilities ☐ Limited abilities (specify)	**Working alone:** ☐ Full abilities ☐ Limited abilities (specify)

F. Additional information:

Has a referral to a specialist been made? ☐ Yes ☐ No ☐ Not Applicable

Referral date: _____ Specialist's name: _____

Is patient on an active treatment plan? ☐ Yes ☐ No

If yes, please indicate frequency _____

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

☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ Other: _____

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

Specify: _____

Start date (dd/mm/yy): _____

Assistive devices required:

☐ Yes ☐ No

Specify: _____

Date of next appointment (dd/mm/yy):

Health Care Professional's signature:

Date completed (dd/mm/yy):

Health Care Professional's name and contact information:

WSIB Provider ID:
(If applicable)

Note: The patient is responsible for the cost of completing the *initial* Abilities Form, except for WSIB claims. The Peel District School Board will assume reasonable and customary payment in all other circumstances.