FITNESS FOR DUTIES FORM

For Planning Early & Safe Return to Work

independent living waterloo region

Employee Name: Meet Baldha	Position: Attendant Service Worker
Work Location: Cambridge	Date of Assessment: 03/27/24
Completed By: Meet Baldha	CPSO #:

PLEASE CHECK ONE:

- [x] Patient is capable of returning to work with **no restrictions**
- [ ] Patient is capable of returning to work **with restrictions** (Complete Section A & B)
- [ ] Patient is **medically unfit** to return to work (Complete Section B)

Note to the Health Care Provider: In order for the Independent Living Centre to facilitate a safe and timely return to work, employees must provide documentation to assist in the development of a modified work plan which appropriately addressing the employee's abilities and limitations. The Independent Living Centre endeavors to accommodate the restrictions you feel are necessary to assist the individual's recovery and rehabilitation.

SECTION A1: Please indicate abilities that apply. Include additional details in section 4.

Walking:	Standing:	Sitting:	Lifting floor to waist:
[x] Full Abilities [ ] Up to 100 meters [ ] 100 – 200 meters [ ] As Tolerated [ ] Other (please specify)	[x] Full Abilities [ ] Up to 15 minutes [ ] 15 – 30 minutes [ ] As Tolerated [ ] Other (please specify)	[x] Full Abilities [ ] Up to 30 minutes [ ] 30 minutes – 1 hour [ ] As Tolerated [ ] Other (please specify)	[x] Full Abilities [ ] Up to 5 kilograms [ ] 5 – 10 kilograms [ ] As Tolerated [ ] Other (please specify)
Lifting waist to shoulder:	**Stair Climbing:**	**Ladder Climbing:**	**Travel to work:**
[x] Full Abilities [ ] Up to 5 kilograms [ ] 5 – 10 kilograms [ ] As Tolerated [ ] Other (please specify)	[x] Full Abilities [ ] Up to 5 steps [ ] 5 – 10 steps [ ] As Tolerated [ ] Other (please specify)	[x] Full Abilities [ ] 1 – 3 steps [ ] 4 – 6 steps [ ] As Tolerated [ ] Other (please specify)	Able to use public transit [x] YES [ ] NO Able to use/drive car [x] YES [ ] NO

SECTION A2: Please indicate restriction that apply. Include additional details in section 4.

[ ] Bending/twisting repetitive movement of (please specify)	[ ] Work at or above shoulder activity	[ ] Chemical exposure to:	[ ] Environmental exposure to: (ex. heat, cold, noise, scents)	[ ] Limited use of hand(s) Left / Right [ ] Gripping [ ] [ ] Pinching [ ] [ ] Other [ ]
Limited Pushing/Pulling [ ] Left Arm [ ] Right Arm [ ] Other	[ ] Operating motorized equipment	[ ] Potential side effects from medications (please specify) Do not include names of medications	[ ] Exposure to exposure vibration [ ] Whole Body [ ] Hand/Arm	[ ] Using Mechanical Lifts [ ] Providing First Aid and/or CPR

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SECTION A3: Specific Cognitive Abilities							
Activity / Situation	**None**	**Mild**	**Moderate**	**Severe**	**Temporary**	**Timeline**	**Permanent**
Concentration	☐	☐	☐	☐	☐		☐
Memory	☐	☐	☐	☐	☐		☐
Decision-Making Ability	☐	☐	☐	☐	☐		☐
Ability to work in groups	☐	☐	☐	☐	☐		☐
Ability to support people with physical disabilities	☐	☐	☐	☐	☐		☐
Ability to Multi-Task	☐	☐	☐	☐	☐		☐
Judgment	☐	☐	☐	☐	☐		☐
Level of Responsibility	☐	☐	☐	☐	☐		☐
Other:	☐	☐	☐	☐	☐		☐

SECTION A4: Additional Comments on Abilities and/or Restrictions

No Restrictions as I'm fully fit to do my duties.

4. From the date of this assessment, the above will apply for:	**5. Have you discussed return to work with your patient?**
☐ 1 – 2 Days ☐ 3 – 7 Days ☐ 8 – 14 Days ☐ 14+ Days	☐ YES ☐ NO
6. Recommendations for work hours:	**7. Start Date (mm-dd-yyyy)**
☑ Regular (Full) Hours ☐ Modified Hours ☐ Graduated Hours	

8. Modified or Graduated Hours

Comments:

SECTION B: Recommended date of next appointment to review Abilities/Restrictions:

Date: _____

DD MM YYYY

03/27/24

Signature of Health Professional **Date:**