Toronto District School Board

Functional Abilities Form - Secondary Teaching

Employee Group:	*Requested By:*
WSIB Claim: ☐ *Yes* ☐ *No*	*WSIB Claim Number:*

To the Employee: The purpose for this form is to provide the Board with information to assess whether you are able to perform the essential duties of your position, and understand your restrictions and/or limitations to assess workplace accommodation if necessary.

Employee's Consent: I authorize the Health Professional involved with my treatment to provide to my employer this form when complete. This form contains information about any medical limitations/restrictions affecting my ability to return to work or perform my assigned duties.

Employee Name: *(Please print)*	Employee Signature:
Employee ID:	Telephone No:
Employee Address:	Work Location:

1: Health Care Professional: The following information should be completed by the Health Care Professional

Please check one:

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

☐ Patient is capable of returning to work with restrictions. Complete section 2 (A&B) & 3

☐ I have reviewed sections 2 (A&B) and have determined that the Patient is totally disabled and is unable to return to work at this time. Complete sections 3 and 4. Should the absence continue, updated medical information will next be requested after the date of the follow up appointment indicated in section 4.

First Day of Absence:	General Nature of Illness *(please do not include diagnosis):*

Date of Assessment:
dd mm yyyy

2A: Health Care Professional to complete. Please outline your patient's abilities and/or restriction based on your objective medical findings.

PHYSICAL (if applicable)

Walking:	Standing:	Sitting:	Lifting from floor to waist
☐ Full Abilities	☐ Full Abilities	☐ Full Abilities	☐ Full Abilities
☐ Up to 100 metres	☐ Up to 15 minutes	☐ Up to 30 minutes	☐ Up to 5 kilograms
☐ 100 – 200 metres	☐ 15 – 30 minutes	☐ 30 minutes – 1 hour	☐ 5 – 10 kilograms
☐ Other (please specify)	☐ Other (please specify)	☐ Other (please specify)	☐ Other (please specify)
Lifting from Waist to Shoulder:	**Stair Climbing**	**Use of hand(s)**	
☐ Full Abilities	☐ Full Abilities	Left Hand	Right Hand
☐ Up to 5 kilograms	☐ Up to 5 steps	☐ Gripping	☐ Gripping
☐ 5 – 10 kilograms	☐ 6 – 12 steps	☐ Pinching	☐ Pinching
☐ Other (please specify)	☐ Other (please specify)	☐ Other (please specify)	☐ Other (please specify)

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Bending/twisting repetitive movement of (please specify):	Work at or above shoulder activity:	Chemical exposure to:	Travel to Work: Ability to use public transit Ability to drive car	☐Yes ☐ No ☐Yes ☐ No
2B: COGNITIVE (please complete all that is applicable)				
Attention and Concentration ☐ Full Abilities ☐ Limited Abilities ☐ Comments	Following Directions: ☐ Full Abilities ☐ Limited Abilities ☐ Comments	Decision-Making/Supervision: ☐ Full Abilities ☐ Limited Abilities ☐ Comments	Mulit-Tasking: ☐ Full Abilities ☐ Limited Abilities ☐ Comments	
Ability to Organize: ☐ Full Abilities ☐ Limited Abilities ☐ Comments	Memory: ☐ Full Abilities ☐ Limited Abilities ☐ Comments	Social Interaction: ☐ Full Abilities ☐ Limited Abilities ☐ Comments	Communication: ☐ Full Abilities ☐ Limited Abilities ☐ Comments	
Please identify the assessment tool(s) used to determine the above abilities (Examples: Lifting tests, grip strength tests, Anxiety Inventories, Self-Reporting, etc.				
Additional comments on Limitations (not able to do) and/or Restrictions (**should/must** not do) for all medical conditions:				
3: Health Care Professional to complete.				
From the date of this assessment, the above will apply for approximately: ☐6-10 days ☐11-15 days ☐16-25 days ☐26 + days		Have you discussed return to work with your patient? ☐ Yes ☐ No		
Recommendations for work hours and start date (if applicable): ☐ Regular full time hours ☐ Modified hours ☐ Graduated hours		Start Date: dd mm yyyy		
Is patient on active treatment plan?: ☐ Yes ☐ No Has a referral to another Health Care Professional been made? ☐ Yes (optional – please specify): ☐ No If a referral has been made, will you continue to be the patient's primary Health Care Provider? ☐ Yes ☐ No				
4: Recommended date of next appointment to review Abilities and/or Restrictions: dd mm yyyy				

Completing Health Care Professional Name: (Please Print)	
Date:	
Telephone Number:	
Fax Number:	
Signature:	

Note for Health Care Professional: Please complete the Form and forward to the following address:
Secondary Teaching Office, 5050 Yonge Street, 2nd Floor, Toronto, Ontario, M2N 5N8
or send by confidential fax to 416-397-3484