

## PHYSICIAN'S ASSESSMENT OF WORK ABILITIES

**Note to Physician: Vancouver Island University provides accommodation to ill or injured employees.**

1. Do not provide diagnosis.
2. This form may be shared with your patient's supervisor or other non-medical staff at Vancouver Island University.
3. The information on this form will be used to help the employee return to work.

**THE PATIENT IS RESPONSIBLE FOR ANY CHARGE INVOLVED FOR THE COMPLETION OF THIS FORM.**

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

### WORK ABILITIES

Demand	Fully Able	Restricted		Demand	Fully Able	Restricted	
Twist/turn	<input type="checkbox"/>	<input type="checkbox"/>		Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	
Bend	<input type="checkbox"/>	<input type="checkbox"/>		Wrist	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>		Grip	<input type="checkbox"/>	<input type="checkbox"/>	
Walk	<input type="checkbox"/>	<input type="checkbox"/>		Judgment	<input type="checkbox"/>	<input type="checkbox"/>	
Sit	<input type="checkbox"/>	<input type="checkbox"/>		Memory	<input type="checkbox"/>	<input type="checkbox"/>	
Squat	<input type="checkbox"/>	<input type="checkbox"/>		Public/Student Contact	<input type="checkbox"/>	<input type="checkbox"/>	
Stand	<input type="checkbox"/>	<input type="checkbox"/>		Multiple Tasks	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>		Concentration	<input type="checkbox"/>	<input type="checkbox"/>	
Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>		Ability to Provide Supervision	<input type="checkbox"/>	<input type="checkbox"/>	
Lift	<input type="checkbox"/>	<input type="checkbox"/>		Ability to Receive Supervision	<input type="checkbox"/>	<input type="checkbox"/>	
Floor to Waist	<input type="checkbox"/>	<input type="checkbox"/>		Ability to Deliver Instruction	<input type="checkbox"/>	<input type="checkbox"/>	
Waist to Shoulder	<input type="checkbox"/>	<input type="checkbox"/>		Ability to Interact with Others	<input type="checkbox"/>	<input type="checkbox"/>	
Above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>		Sight	<input type="checkbox"/>	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	<input type="checkbox"/>		Hearing	<input type="checkbox"/>	<input type="checkbox"/>	
Work Hours	<input type="checkbox"/>	<input type="checkbox"/>		Speech	<input type="checkbox"/>	<input type="checkbox"/>	
Work Shifts	<input type="checkbox"/>	<input type="checkbox"/>		Operating Machinery/ Vehicles	<input type="checkbox"/>	<input type="checkbox"/>	
				Working at Heights	<input type="checkbox"/>	<input type="checkbox"/>	

This employee is participating in a treatment plan. Yes \_\_\_\_\_ No \_\_\_\_\_ Reason: \_\_\_\_\_

This Employee will need to attend appointments at the following intervals: \_\_\_\_\_

Not capable of working in any capacity: \_\_\_\_\_

Estimated duration of restriction/incapacity: \_\_\_\_\_

- |                                     |                                     |  |                                    |
|-------------------------------------|-------------------------------------|--|------------------------------------|
| <input type="checkbox"/> _____ days | <input type="checkbox"/> 2-4 weeks  | <input type="checkbox"/> 4-6 weeks             | <input type="checkbox"/> 6-8 weeks |
| <input type="checkbox"/> 8-10 weeks | <input type="checkbox"/> > 10 weeks | <input type="checkbox"/> long-term _____ weeks | <input type="checkbox"/> permanent |

Estimated return to work date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_

**Physician: Please complete this form for the employee named above and return it immediately to:**



Human Resources Department  
900 Fifth Street  
Nanaimo, BC V9R 5S5