Staff Wellness

Functional abilities form

Faculty and staff | For work injuries only

UNIVERSITY OF CALGARY

Return completed form to your **Reports-to Manager** and send it confidentially to **Staff Wellness** by fax 403.282.8603 or email staffwellness@ucalgary.ca.

Physicians are asked NOT to provide a diagnosis or information about the nature of injury, or any information unrelated to the specific restrictions/limitations on this form.

To be completed by faculty/staff member

Name:	**Date of birth:**
Position:	**Work location:**
Phone:	**Email address:**

This information is being collected under the authority of Section 33(c) of the Alberta Freedom of Information and Protection of Privacy Act (FOIP), will be used for the purpose(s) of return to work coordination and is protected by the privacy provisions of FOIP. If you require further information regarding the collection and use of this information, contact Staff Wellness at 403.220.2918

Faculty / Staff Signature:	**Date:**

Dear Doctor

Consistent with the Canadian Medical Association policy on return to work, we agree that prolonged absence from one's normal roles, including absence from the workplace, is detrimental to an individual's mental, physical, and social well-being. When possible, the university provides modified work to meet the temporary and permanent accommodation needs of our employee and Staff Wellness provides services to support return to work as soon as medically suitable.

Please invoice the University of Calgary directly, including invoice number, date and university address (2500 University Drive NW, Calgary, AB T2N 1N4). A reporting fee of $50 will be paid.

To be completed by physician (please print clearly in all applicable areas)

Date of assessment:

Current functional abilities (please make a selection below as they rate to the injury)

Sitting:	☐ Able	☐ Unable	☐ Limited to _____ hours per shift/day
Standing:	☐ Able	☐ Unable	☐ Limited to _____ hours per shift/day
Walking:	☐ Able	☐ Unable	☐ Limited to _____ hours per shift/day
Bending:	☐ Able	☐ Unable	☐ Limited
Kneeling/squatting:	☐ Able	☐ Unable	☐ Limited
Climbing:	☐ Able	☐ Unable	☐ Limited
Lifting:	☐ Able	☐ Unable	☐ Limited to _____ lbs
Pushing/pulling:	☐ Able	☐ Unable	☐ Limited to _____ lbs
Overhead reaching:	☐ Able	☐ Unable	☐ Limited to
Driving:	☐ Able	☐ Unable	☐ Limited to _____ hours per day

Other restrictions or additional comments/special considerations:

Estimated date fit for pre-accident work:

Reassessment required? ☐ Yes ☐ No	**If Yes, appointment date:**

Treatment provider's name, address, phone and fax number:	**Treatment provider's signature:**
	Date: