UNIVERSITY OF CALGARY

Fitness for Work Form - Faculty

Send completed form to confidential fax 403-282-8603

TO BE COMPLETED BY FACULTY MEMBER		
Name:	ID#:	Date of birth:
Faculty Position:	Faculty/Department:	
Home phone or cell #: ( )	E-mail address:	
First day off work:	Is this an: ☐ Illness ☐ Injury	

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 payroll and benefit administration 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. You will be reimbursed for any physician fee for the completion of this form in accordance with the University's expense reimbursement procedures.

Faculty member signature: ____________________________ Date: ____________________

TO BE COMPLETED BY PHYSICIAN (please print clearly in all applicable areas)

When completing this form, please keep in mind that faculty positions do not have standard job descriptions but will often include teaching, research and administration. If you determine that the faculty member can perform portions of his/her role, we may be able to accommodate his/her abilities.

Is this health issue: ☐ Work related ☐ Non-work related

Date of symptoms onset:	Date of first visit for this absence:

Primary nature of illness/disability:

Do co-morbid conditions exist: ☐ Yes ☐ No If yes, please explain

Is the condition: ☐ Improving ☐ Unchanged ☐ Deteriorating

Has an active treatment plan been prescribed: ☐ Yes ☐ No

Is the patient compliant with treatment plan: ☐ Yes ☐ No

Is the patient:

☐ Fit to return to work to own position

☐ Fit to return to work with limitations or fit for modified/alternate work with limitations and/or restrictions identified on page 2

☐ Unfit for modified/alternate duties

Please outline clinical findings or objective medical information that support the fitness for work:		
Please list limitations and/or restrictions (e.g. physical/cognitive limitations and/or hours of work):		
Date of re-evaluation of restrictions:		
Estimated return to work date(s)		Is complete recovery expected:
Modified duties:	Full duties:	☐ Yes ☐ No ☐ Unknown
Is a follow-up reassessment required? ☐ Yes ☐ No If yes, appointment date:		
Prognosis:		
Will the patient require time off during the return to work plan to attend treatment plan appointments: ☐ Yes ☐ No If yes, provide details:		

Physician name:	
Physician signature:	Date:
Mailing Address:	
Phone #: ( )	Fax #: ( )
Please bill your patient directly for the completion of this form	

Thank you for your assistance.

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