HASTINGS AND PRINCE EDWARD DISTRICT SCHOOL BOARD

FORM 423-4	
Adopted	August 20, 2015
Last Revised	February 2019
Review Date	February 2024

OSSTF FUNCTIONAL ABILITIES FORM

CONFIDENTIAL

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

To the Employee: The purpose of this form is to provide the Hastings and Prince Edward District School board with information to assess your ability to perform your essential duties and/or eligibility for benefits. You are our most valued asset to our schools!

Employee's Consent: I authorize the Health Care Professional involved with my treatment to provide this form when complete to the Wellness and Disability Management Officer. This form contains information about any medical limitations/restrictions affecting my ability to return to modified work or my regular assignment.

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

Dear Health Care Practitioner: HPEDSB is requesting that our employee receive from you, an assessment that will assist our Kinesiologist with appropriate workplace accommodation(s) and benefits. We encourage our employees to consult with their Health Care Professional(s) about an early and safe return to work. **Diagnostic or confidential information must not be included.**

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 restrictions 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):**	
		Left Hand	**Right Hand**
☐ Full abilities	☐ Full abilities	☐ Gripping	☐ Gripping
☐ Up to 5 kilograms	☐ Up to 5 steps	☐ Pinching	☐ Pinching
☐ 5 - 10 kilograms	☐ 6 - 12 steps	☐ Other (*please specify*):	☐ Other (*please specify*):
☐ Other (*please specify*):	☐ Other (*please specify*):		

☐ **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:	**Multi-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:

Additional comments on **Limitations (not able to do) and/or Restrictions (<u>should/must</u> 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 an 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: _____

The Hastings and Prince Edward District School Board offers immediate, confidential help for any concern through our Employee Assistance Program (1-844-671-3327 or online at one.telushealth.com – Username: HPE Password: wellbeing) which can help employees with issues including, but not limited to:

- Stress
- Marital/family/separation/divorce/custody issues
- Alcohol and drug abuse
- Personal adjustment problems
- Weight, smoking and general health issues
- Psychological disorders
- Anger management
- Retirement planning
- Aging parents/eldercare concerns
- Gambling addiction
- Conflict resolution
- Bereavement
- Sexual harassment

<u>Please Note</u>: PDA/CDA is also available upon request

PLEASE RETURN THE COMPLETED FORM TO OUR CONFIDENTIAL HUMAN RESOURCES FAX NUMBER 613-966-1397

Information collected on this form will be used in accordance with the Municipal Freedom of Information and Protection of Privacy Act for the purposes noted above. Information will be shared with school board employees as required to carry out their job duties and for consistent purposes. Questions regarding this form should be directed to Human Resources Support Services at 1-800-267-4350 or 613-966-1170.