A-1 Physician's Return to Work/Accommodation Clearance Certificate

Part A: To be completed by the employee

Name:(Print)		Tel:
Worksite	Unit/Dept:	Job Title:

Status: Regular ☐ Part-time ☐ Casual ☐
Hrs of work: Per day _____ Per week _____

Shift schedule: D _____ E_____ N_____ Rotation:

Date of disability, injury/onset of illness (d/m/y):

Start date of current: absence ___ limitations ___ Date (d/m/y):

I authorize my physician(s) to provide my employer's Occupational Health Department the following information on my limitations and capabilities in order to facilitate my return to work program/establish my need for accommodation.

Employee signature:	**Date (d/m/y):**

B. Background information provided to physician

Job description ☐ Task demand analysis report ☐ Functional capacity evaluation report ☐

Other ☐ Explain:

C. To be completed by attending physician:

Last appointment/examination date (d/m/y):

Return to work parameters:

Is your patient able to return to perform:

- own job - no limitations yes ☐ Date (d/m/y) : _____ no ☐ (see next page)
- own job through gradual return to work program yes ☐ no ☐ (see next page)

If gradual return to work program is required:
Date patient is cleared to commence gradual return to work program: (d/m/y): _____
Anticipated length of gradual return to work program: _____

Outline of return to work schedule:

Accommodation parameters:

Unable to return to regular position/duties, requires Accommodation ☐

Need for accommodation is:

Permanent ☐ Prolonged ☐ Approximate length: _____

Temporary ☐ or end date (d/m/y) _____

Able to return to: own position, if accommodated ☐

alternate position, if accommodated ☐

What modifications does your patient require?

Schedule	☐	Length of shift(s)	☐
Time of shifts(d/e/n)	☐	Environmental modifications	☐
Equipment/assistive devices	☐	Changes to Work tasks	☐
Other	☐		

Please explain above indicated modification(s):

Outline of restrictions/functional abilities (with consideration to safe performance of duties)

What are your patient's functional limitations and restrictions or the degree of those limitations/restrictions on work related activities?

1	☐	Sitting	
2	☐	Standing	
3	☐	Walking	
4	☐	Balance	
5	☐	Pushing	
6	☐	Pulling	
7	☐	Lifting (indicate max. limit)	_____☐ lbs ☐ kgs
8	☐	Carrying (indicate max. limit)	_____☐ lbs ☐ kgs

(continued on next page)

Functional limitations and restrictions (continued)

9	☐	Reaching (indicate at what level):		above head	☐
		above shoulder (s)	☐	above waste	☐
		below waste	☐	below hips	☐
		below knees	☐	floor level	☐
10	☐	Bending or stooping			
11	☐	Remaining in one position for a prolonged time			
12	☐	Crouching			
13	☐	Use or dexterity of hands & fingers			
14	☐	Kneeling			
15	☐	Ascending/descending stairs			
16	☐	Driving			
17	☐	Performing any unusual motion			
18	☐	Sensation			
19	☐	Psychological			
20	☐	Concentration			
21	☐	Memory			
22	☐	Cognitive function			
23	☐	Ability to multi-task			
24	☐	Ability to work in stressful situations			
25	☐	Visual Acuity (near, far, night vision)			
26	☐	Speech			
27	☐	Hearing			
28	☐	Administration of medications			
29	☐	Work environment exposures (eg. latex, chemicals, pharmaceuticals)			
30	☐	Ability to supervise others			
31	☐	Any other functions limited by illness or injury			
32	☐	Allergy - Explain: _____			
33	☐	Other - Explain: _____			

Please explain/comment, indicating degree of limitation(s) - use extra page if necessary:

Please indicate any other job functions limited by your patient's disability/medical condition or treatment your patient is receiving:

Physician's name (print or use stamp):

Physician's signature: Date (d/mo/yr)

We thank you for your assistance. Please return this form to your patient.