TORONTO

Return to Work Information

SECTION A: To be completed by the employer

☐ Initial form ☐ Follow-up

Social Insurance No.	Claim Number (if available)	Employee No.
Worker's Last Name	First Name	Home Telephone ( )
Home Address		Postal Code
Date of Accident / Onset of Illness	Area of Injury (if applicable)	
Job at time of Accident / Illness		Physical Demands Analysis enclosed ☐ Yes ☐ No
Department / Division	Supervisor	Telephone
Work Address		Work Telephone

SECTION B: To be completed by the treating health professional and returned to the worker

Nature of problem ☐ medical illness ☐ injury (please indicate) .....

Estimated recovery time ..... Is complete recovery expected ☐ Yes ☐ No

Please specify further treatment required, if any .....

Ability to return to work (check one):

☐ Able to return to work immediately without restrictions

☐ Able to return to modified duties. Modified duties are recommended for ..... days or ..... weeks

☐ Unable to participate in any work, including modified duties for ..... days or ..... weeks

If modified duties are required, please check any specific medical restrictions necessary:

LIFTING (floor to knuckle)	☐ No loads > 20 kg	☐ No loads > 10 kg	☐ Occasional lifting only
LIFTING (knuckle to chest)	☐ No loads > 20 kg	☐ No loads > 10 kg	☐ Occasional lifting only
LIFTING (above chest)	☐ No loads > 20 kg	☐ No loads > 10 kg	☐ Occasional lifting only
CARRYING	☐ No loads > 20 kg	☐ No loads > 10 kg	☐ Occasional carrying only
PUSHING / PULLING	☐ No heavy pushing / pulling	☐ Occasional pushing / pulling only	☐ Avoid pushing / pulling
HAND FUNCTION	☐ Avoid repetitive hand motion	☐ No strong gripping	☐ Avoid gripping
REACHING	☐ No prolonged overhead reaching	☐ No overhead reaching	☐ Avoid any reaching
SITTING	☐ No prolonged sitting		
STANDING	☐ No prolonged standing	☐ Avoid standing	
WALKING	☐ No prolonged walking	☐ Avoid uneven ground	☐ Avoid walking
CLIMBING (stairs / ladders)	☐ Occasional climbing only	☐ No ladder climbing	
BENDING	☐ No prolonged bending	☐ Occasional bending only	☐ Avoid bending
CROUCHING /KNEELING	☐ No prolonged crouching / kneeling	☐ Occasional crouching / kneeling only	☐ Avoid crouching / kneeling

Are there any contraindications to the testing process if the City's disability management staff recommend this employee for functional abilities testing ☐ Yes ☐ No

Comments / Specific limitations: Please describe any additional related medical restrictions pertaining to – effects of medication, driving vehicles or operating equipment, physical exertion, vibration, work environment, work hours.

Health professional's name and title (please print) .....

Address ..... Postal Code .....

Telephone ( ) ..... Signature ..... Date .....

Examination date ..... Next appointment date .....

SECTION C: Worker Consent (to be completed by worker):

I authorize the health professional involved with my treatment to provide to me, my employer, and the Workplace Safety and Insurance Board (if applicable) this completed form containing information about any limitations / restrictions affecting my ability to return to work.

Signature ..... Date .....