TOWN OF NEWMARKET
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Newmarket, ON L3Y 4X7

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905.953.5333

FUNCTIONAL ABILITIES FORM
NON-WORK RELATED INJURY OR ILLNESS

The Town of Newmarket has a dynamic Return to Work Program where injured/disabled workers are provided with workplace accommodation that allows them to ease back to a full workload gradually. We are able to provide accommodation and modified duties throughout the corporation. You can assist us in planning for this worker's early rehabilitation by providing information on this report.

Thank-you for your co-operation in our reintegration of this worker back to productive work that will not aggravate the worker's injury/illness, nor constitute an additional hazard to the worker or fellow workers while performing the work assigned.

Please feel free to contact the Town of Newmarket Human Resources Department if we can be of any further assistance to you at 905-953-5333.

SECTION A Completed by the Employee

Employee's Last Name	First Name	Telephone	
Address (no, street, apt)	City/Town	Province	Postal Code
Position Held		Length of Time in Position	

SECTION B Employee's Signature

By signing below, I am authorizing any health professional who treats me to provide me and my employer with information about my functional abilities for planning early and safe return to the work place.	
Signature:	Date: dd/mm/yyyy

SECTION C

Health Care Professional's Designation ☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse ☐ Other _____			
Health Care Professionals Name (please print)			
Address (no, street, apt)	City/Town	Prov.	Postal Code
Telephone	Fax		
Health Professionals Signature:	Date dd/mm/yyyy		

SECTION D Completed by Health Care Professional to identify the patient's overall abilities and limited abilities

Date of Injury/Illness dd/mm/yyyy:			
Date of Assessment dd/mm/yyyy	Please Check One □ Employee is capable of returning to work with **full abilities**	□ Employee is capable of returning to work **limited abilities** Complete Sections **E** and **F**	□ Employee is physically unable to return to work at this time (**including modified duties**) Complete Sections **E** and **F** to verify limited abilities.

SECTION E – Abilities

1. Please indicate **ABILITIES** that apply, **Include details in Section 3**

Walking abilities: □ Full Abilities □ Up to 100 metres □ 100-200 metres □ Other (please specify)	**Standing abilities:** □ Full Abilities □ Up to 15 minutes □ 15 – 30 minutes □ Other (please Specify)	**Sitting abilities:** □ Full Abilities □ Up to 30 minutes □ 30 minutes – 1 hour □ Other (please specify)	**Lifting from floor to waist abilities:** □ Full Abilities □ Up to 5 kilograms □ 5 – 10 kilograms □ Other (please specify)	
Lifting from waist to shoulder abilities: □ Full Abilities □ Up to 5 kilograms □ 5 – 10 kilograms □ Other (please specify)	**Stair Climbing abilities:** □ Full Abilities □ Up to 5 steps □ 5 – 10 steps □ Other (please specify)	**Ladder Climbing abilities:** □ Full Abilities □ 1 – 3 steps □ 4 – 6 steps □ Other (please specify)	**Able to travel to** Ability to use public transit □ Yes □ No	**work** Ability to drive a car □ Yes □ No
Pushing with: □ Left Arm □ Right Arm □ Other (please Specify)	□ **Operating motorized equipment (e.g. forklift)**	□ **Potential Side effects from medications (please specify)** Do not include names of medications	□ **Exposure to Vibration** □ Whole Body □ Hand / Arm	

□ Stamina / Energy abilities (please specify)	□ Hearing – Speech abilities (please specify)	□ Vision abilities (please specify)
□ Operate motorized equipment abilities (please specify)	□ Concentration abilities (please specify)	□ Interact with others abilities (please specify)
□ Understanding / Memory abilities (please specify)	□ Read – Write activities (please specify)	□ Computer Usage abilities (please specify)
□ Tactile – Feeling abilities (please specify)	□ Performance of multiple tasks abilities (please specify)	□ Work to Speed abilities (please specify)
□ Communication / Comprehension abilities (please specify)	□ Other abilities related to the position:	

2. Please indicate **LIMITED ABILITIES** that apply. **Include details in section 3**.

☐ Bending / Twisting repetitive movement of _____ (please specify)	☐ Work at or above shoulder activity	☐ chemical exposure to: _____ **(please specify)**	☐ Environmental exposures to (e.g. heat, cold, noise, scents)	☐ Limited use of the hand (s)		
				Left		Right
				☐	Gripping	☐
				☐	Pinching	☐
				☐	Other (specify)	☐

3. DETAILS and additional Comments on **Abilities and / or limited abilities including time lines.**

4. From the date of this assessment, the above will apply for approximately

☐ 1-2 days	☐ 3 – 7 days	☐ 8-14 days	☐ 14 days

5. The Town of Newmarket has a dynamic return to work program and is able to accommodate modified duties throughout the corporation. Have you discussed return to work with your patient?

☐ Yes	☐ No

6. Recommendations for work hours and start date:

Hours of Work	**Start Dates (dd/mm/yyyy)**	**End Dates (dd/mm/yyyy)**
☐ Regular Full Time hours		
☐ Modified Hours **(please specify)**		
☐ Graduated Hours **(please specify)**		

SECTION F – Date of Next appointment

Recommended date of next appointment to review **Abilities and/or limited abilities:**	**DATE (dd/mm/yyyy)**

Additional Notes that will aid in planning the return to work of the employee:

This information can be faxed to the confidential Human Resources fax number 905-953-5337