CUPE SUPPORT STAFF

PHYSICIAN'S ASSESSMENT OF WORK ABILITIES

Note to Physician: Vancouver Island University provides accommodation to ill or injured employees.

1. **Do not provide diagnosis.**
2. This form may be shared with your patient's supervisor or other non-medical staff at Vancouver Island University.
3. The information on this form will be used to help the employee return to work.

THE PATIENT IS RESPONSIBLE FOR ANY CHARGE INVOLVED FOR THE COMPLETION OF THIS FORM.

Employee Name:_______________________________ Date:_______________________________

WORK ABILITIES

Demand	Fully Able	Restricted		Demand	Fully Able	Restricted	
Twist/turn	☐	☐		Shoulder	☐	☐	
Bend	☐	☐		Wrist	☐	☐	
Climb	☐	☐		Grip	☐	☐	
Walk	☐	☐		Judgment	☐	☐	
Sit	☐	☐		Memory	☐	☐	
Squat	☐	☐		Public/Student Contact	☐	☐	
Stand	☐	☐		Multiple Tasks	☐	☐	
Balance	☐	☐		Concentration	☐	☐	
Push/Pull	☐	☐		Ability to Provide Supervision	☐	☐	
Lift	☐	☐		Ability to Receive Supervision	☐	☐	
Floor to Waist	☐	☐		Ability to Deliver Instruction	☐	☐	
Waist to Shoulder	☐	☐		Ability to Interact with Others	☐	☐	
Above Shoulder	☐	☐		Sight	☐	☐	
Neck	☐	☐		Hearing	☐	☐	
Work Hours	☐	☐		Speech	☐	☐	
Work Shifts	☐	☐		Operating Machinery/ Vehicles	☐	☐	
	☐	☐		Working at Heights	☐	☐	

This employee is participating in a treatment plan. *Yes* ____________ *No* __________ Reason ______________________________

____

This employee will need to attend appointments at the following intervals: ______________________________

Is the employee able to work in any capacity? Please describe ______________________________

Are there restrictions on the type of work that the employee can perform? If Yes, please describe the restrictions: ______________

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Estimated duration or restriction/incapacity: ______________________________

☐____________days ☐ 2 – 4 weeks ☐ 4 – 6 weeks ☐6 – 8 weeks
☐ 8 – 10 weeks ☐ > 10 weeks ☐ long-term ____weeks ☐ permanent

Estimated return to work date: ______________________________

Will the employee's medical condition be likely to cause any absenteeism in the future? ______________________________

____

Physician's Signature: ______________________________ Date:______________________

Physicians Name (please print): ______________________________

Physician: Please complete this form for the employee named above and return it immediately to:

Vancouver Island University
Human Resources Department
900 5th Street, Nanaimo, BC V9R 5S5