

**FACULTY / ADMINISTRATION COMMON DISABILITY PLAN**

**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	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	Grip	<input type="checkbox"/>	<input type="checkbox"/>
Walk	<input type="checkbox"/>	<input type="checkbox"/>	Judgment	<input type="checkbox"/>	<input type="checkbox"/>
Sit	<input type="checkbox"/>	<input type="checkbox"/>	Memory	<input type="checkbox"/>	<input type="checkbox"/>
Squat	<input type="checkbox"/>	<input type="checkbox"/>	Public/Student Contact	<input type="checkbox"/>	<input type="checkbox"/>
Stand	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Tasks	<input type="checkbox"/>	<input type="checkbox"/>
Balance	<input type="checkbox"/>	<input type="checkbox"/>	Concentration	<input type="checkbox"/>	<input type="checkbox"/>
Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>	Ability to Provide Supervision	<input type="checkbox"/>	<input type="checkbox"/>
Lift	<input type="checkbox"/>	<input type="checkbox"/>	Ability to Receive Supervision	<input type="checkbox"/>	<input type="checkbox"/>
Floor to Waist	<input type="checkbox"/>	<input type="checkbox"/>	Ability to Deliver Instruction	<input type="checkbox"/>	<input type="checkbox"/>
Waist to Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Ability to Interact with Others	<input type="checkbox"/>	<input type="checkbox"/>
Above Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Sight	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Work Hours	<input type="checkbox"/>	<input type="checkbox"/>	Speech	<input type="checkbox"/>	<input type="checkbox"/>
Work Shifts	<input type="checkbox"/>	<input type="checkbox"/>	Operating Machinery/ Vehicles	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Working at Heights	<input type="checkbox"/>	<input type="checkbox"/>

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: \_\_\_\_\_

Estimated duration or restriction/incapacity: \_\_\_\_\_

- |                                       |                                      |  |                                      |
|---------------------------------------|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> _____ days   | <input type="checkbox"/> 2 – 4 weeks | <input type="checkbox"/> 4 – 6 weeks           | <input type="checkbox"/> 6 – 8 weeks |
| <input type="checkbox"/> 8 – 10 weeks | <input type="checkbox"/> > 10 weeks  | <input type="checkbox"/> long-term _____ weeks | <input type="checkbox"/> 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 5<sup>th</sup> Street, Nanaimo, BC V9R 5S5