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Ed Mirvish Enterprises Limited
Functional Abilities Form - Non-Occupational Injury/Illness

Note to Medical Provider: Please completely fill out the applicable sections of this form to assist us in determining appropriate and safe modified duties. Thank you.

Employee Name: _____ **Employee Title:** _____

I,_____have been absent from work since_____

I authorize the release of the information below to my employer.

Employee Signature: _____ Date: _____

Please return this form by fax, email or return with employee.

To be completed by Medical Professional

Date of Assessment: _____ Injury/Illness Area: _____ ☐ Patient is capable of returning to work with **no restrictions**. ☐ Patient is capable of returning to work **with restrictions**.	Is complete recovery expected within 5-12 days? Yes ☐ No ☐ **Anticipated date, return to full duties**_____ **Assuming complete recovery and return-to-work:** ❑ Complete recovery is expected. ❑ Yes ❑ No ❑ Estimated RTW date on pre-disability duties/hours with no restrictions: _____ ❑ Able to maintain regular attendance? ❑ Yes ❑ No

Please identify functional capacity and/or restrictions and quantify, where able:
Restrictions:

❑ Walking: _____ ❑ Standing: _____

❑ Sitting: _____ ❑ Lifting (floor to waist): _____

❑ Lifting (waist to shoulder): _____ ❑ Stair climbing: _____

❑ Ladder climbing: _____ ❑ Use of hands: _____

❑ Bending or twisting of: _____ ❑ Repetitive movement of: _____

❑ Above shoulder activity: _____ ❑ Below shoulder activity: _____

❑ Work With Others: _____ ❑ Manage Emotions: _____

❑ Concentrate on Tasks: _____ ❑ Exercise Appropriate Behavior: _____

❑ Above shoulder activity: _____ ❑ Below shoulder activity: _____

❑ Writing, Typing, Speaking or Hearing,:_____

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❑ Restrictions/Side effects related to medications (specify): ❑ Other restrictions/comments:

Prognosis and recommendation of work hours during the period of restrictions noted above: ❑ Full-time hours (duration of restrictions): _____ ❑ Modified hours (specify hours & duration): _____ ❑ Graduated hours (specify increases & duration): _____	Is medical support provided for return-to-work? ☐ Yes (Full duties/no restrictions) RTW date: _____ ☐ Yes (with restrictions noted below) RTW date: _____ ☐ No, not at this time: • estimated date for RTW with/without restrictions: _____

The Employer has a modified duties program in place. Have you discussed modified duties as part of the rehabilitation/treatment plan?

Additional Comments:

Medical Provider's name (print): _____ Date: _____

Address: _____ Profession: _____

Medical Provider's signature _____

<u>Forward by email or fax to:</u> your manager or the HR Coordinator at (416) 593-7759 or jlagoda@mirvish.com