Functional Abilities Form

Section A- EMPLOYEE DETAILS: Employee to Complete

Employee Name: _____ Date of Birth: _____
Job Title: _____ Department: _____

Section B- SICK LEAVE DETAILS: **Physician/Medical Practitioner to Complete**

Date of Assessment: _____ **Date cleared for return to work**:_____
Is the current disability work-related? ☐ yes ☐ no
Please check one: ☐ Patient capable of returning to work with no limitations
☐ Patient is unable to return to work at this time
☐ Patient is capable of returning to work with restrictions (complete Section C)
Estimated Duration of Limitations:_____
Prognosis: _____
Follow-up appointment date: _____ ☐ No follow up appointment required
Print name of Physician: _____ Physician Signature: _____Date:_____

Section C- WORKPLACE FUNCTIONAL CAPACITY: **Physician/ Medical Practitioner to complete when accommodation is requested.**

Nature of Condition (do not include diagnosis) : _____
Functional Limitations

Walk Continuously	Limit to_____ minutes/ hours		
Stand Continuously	Limit to _____minutes/ hours		
Sit Continuously	Limit to _____minutes/ hours		
Bend/ Twist	☐ Avoid Repetitive	☐ Limit to _____	
Push/ Pull	☐ Avoid Repetitive	☐ Limit to _____ minutes/hours	Kg_____
Lift: ☐ Floor to waist	☐ Avoid Repetitive	☐ Limit to _____ minutes/hours	Kg_____
☐ Waist to shoulder	☐ Avoid Repetitive	☐ Limit to _____ minutes/hours	Kg_____
☐ Above shoulder	☐ Avoid Repetitive	☐ Limit to _____ minutes/hours	Kg_____
Limited pushing/pulling:	☐ Avoid Repetitive	☐ Limit to _____ minutes/hours	Kg_____

☐ Restrictions due to medication(s) that may interfere with position (explain) _____
☐ Other (explain)_____

Recommendation of Hours: ☐Full-Time ☐Modified Hours (specify)_____

Cognitive/Psychological Limitations:		Comments:
☐ Difficulties performing simple and repetitive tasks	☐ Limitation ☐ No Limitation	_____
☐ Adaption/ Ability to Accommodate Change	☐ Limitation ☐ No Limitation	_____
☐ Attention to detail/ Concentration	☐ Limitation ☐ No Limitation	_____
☐ Limited ability to perform multiple, complex and varied tasks	☐ Limitation ☐ No Limitation	_____
☐ Communication/ Comprehension	☐ Limitation ☐ No Limitation	_____
☐ Reduced energy and pace required for the job	☐ Limitation ☐ No Limitation	_____
☐ Responsibility/ Accountability/ Decision Making	☐ Limitation ☐ No Limitation	_____
☐ Difficulty maintaining healthy co-worker relationships	☐ Limitation ☐ No Limitation	_____
☐ Understanding/ Memory	☐ Limitation ☐ No Limitation	_____
☐ Ability to work to Deadlines	☐ Limitation ☐ No Limitation	_____
☐ Problems maintaining focus/concentration on the job	☐ Limitation ☐ No Limitation	_____
☐ Exposure to Environmental Stimuli/ Distractions	☐ Limitation ☐ No Limitation	_____
☐ Operation of motorized equipment	☐ Limitation ☐ No Limitation	_____

☐ Other:_____

Note: Any costs associated with providing this information is the responsibility of the employee.

Please return the completed document to the Human Resources Department to: hr@kings.uwo.ca or Fax: 519-433-6058
King's University College, Human Resources, Wemple Building, 266 Epworth Ave., London, ON, N6A 2M3