Functional Abilities Assessment

Employee's Name: _____

Occupation: _____ **Date of Injury / Illness:** _____

No change to preinjury state
This form is to be completed by the physician attending the employee.
Please return to employee or FAX 250.475.4113 or injuryreporting@sd61.bc.ca

Injury:

_____

Assessment is based on which factors indicated below:

☐ Information provided by the patient.
☐ My examination of the patient and my assessment of the findings and health information.

Physical Abilities

Walking:	☐ No Restrictions ☐ Up to 1 hour ☐ Up to 3 hours ☐ Up to 6 hours ☐ Other _____	☐ Some Restrictions Please indicate the duration: _____	☐ No Walking
Standing:	☐ No Restrictions ☐ Up to 1 hour ☐ Up to 3 hours ☐ Up to 6 hours ☐ Other _____	☐ Some Restrictions Please indicate the duration: _____	☐ No Standing
Sitting:	☐ No Restrictions ☐ Up to 1 hour ☐ Up to 3 hours ☐ Up to 6 hours ☐ Other _____	☐ Some Restrictions Please indicate the duration: _____	☐ No Sitting
Climbing: (stairs / ladders)	☐ No Restrictions (no. of stairs or times per shift)	☐ Some Restrictions Please indicate the duration: _____	☐ No Climbing
Carrying / Lifting / Push / Pull:	☐ No Restrictions ☐ Up to 5 lbs. ☐ Up to 10 lbs. ☐ Up to 20 lbs. ☐ Other _____	☐ Some Restrictions Please indicate the duration: _____	☐ No Carrying/Lifting/Pushing/Pulling
Bending / Twisting:	☐ Some Restrictions Limit to _____ bends per _____	☐ No Restrictions ☐ No Bending Please indicate the duration: _____	
Shoulder Movements:	☐ No Restrictions ☐ Some Restrictions ☐ No Above Shoulder ☐ No Below Waist ☐ No Arm Extension ☐ No Shoulder Movement	Please indicate the duration: _____	

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Environmental

Exposure to non-extreme heat / cold:	☐ No Restrictions	☐ Some Restrictions (indicated below)
Exposure to common odours:	☐ No Restrictions	☐ Some Restrictions (indicated below)
Exposure to sensory inputs:	☐ No Restrictions	☐ Some Restrictions (indicated below)

Mental Abilities

Thinking / Reasoning:	☐ No Restrictions	☐ Some Restrictions (indicated below)
Concentration:	☐ No Restrictions	☐ Some Restrictions (indicated below)
Critical decision-making:	☐ No Restrictions	☐ Some Restrictions (indicated below)
Interpersonal contact:	☐ No Restrictions	☐ Some Restrictions (indicated below)
Alertness:	☐ No Restrictions	☐ Some Restrictions (indicated below)

Other Abilities

Operating vehicle:	☐ No Restrictions	☐ Some Restrictions (indicated below)
Operating equipment:	☐ No Restrictions	☐ Some Restrictions (indicated below)
Working at heights:	☐ No Restrictions	☐ Some Restrictions (indicated below)

Additional Limitations / Restrictions Comments

This form will be used to provide guidance on ensuring our employee is effectively supported in a gradual return to full health and duties
Please note: The District will reimburse or pay directly to clinic costs associated with completion of the Medical Certificate, using the 2023 BCMA uninsured service fee rate (as of April 1, 2023: Form A00060; $50.00).

Thank you for your expertise and supporting the effective care and recovery to full abilities of your patient

Next appointment: _____

Facility Name: _____

Physician's Name: _____

Physician's Signature: _____

Date: mm/dd/yyyy _____

Clinic / Physician Stamp