Sample Medical Ability to Work Form (Page 1 of 2)

(To be completed by attending physician)

The purpose of this form is to provide the patient with the necessary information that they need to give to their employer to help the employer make decisions about accommodating the patient, providing disability leave, or assessing if the patient can return to work.

Notes to physician

1. This form is not intended for Workers' Compensation Board (WCB) purposes. For a work-related injury or illness, the required WCB forms must be completed.
2. This form **does not replace** forms related to an employee's ability to work that are required by:
   - Workers' Compensation Board,
   - third-party insurers, or
   - employer-funded medical benefit plans.
3. Where choices are indicated below, please mark your selection.
4. Please sign and date both pages 1 and 2, and keep a copy of this form.

When completing this form, disclose only information necessary to meet the purpose of the form. Typically, it is not necessary to provide a diagnosis or treatment information.

Physician's name and address (typewritten or printed)

_____

_____

I saw _____ on _____.
(Print patient's name) (Date)

Date of injury or illness _____.
(Date)

This patient is medically able to work with limitations or restrictions as of _____.
(Date)

Restrictions or limitations (see page 2 for details)

In my opinion, these restrictions or limitations are:

☐ Temporary:
- ☐ _____ days
- ☐ less than 2 weeks
- ☐ 2 to 4 weeks
- ☐ 4 to 6 weeks
- ☐ 6 weeks to 3 months
- ☐ more than 3 months

☐ Permanent

Date of next appointment is (indicate **n/a** if not applicable) _____.
(Date)

My opinion is based on the factors indicated below:

☐ Information provided by the patient

☐ My examination of the patient and my assessment of the findings and health information

I have provided this form to the patient named above.

_____ _____
(Physician's signature) (Date)

NOTE: Completion of this form is an uninsured medical service. There may be a fee to the patient for completion of this form.

Alberta Human Rights Commission developed this form in consultation with the Alberta Federation of Labour, Alberta Medical Association, Alberta Workers' Health Centre, and the College of Physicians and Surgeons of Alberta. **This sample form is an appendix to the Commission interpretive bulletin *Obtaining and responding to medical information in the workplace,* which is available from the Commission or online at www.albertahumanrights.ab.ca.**

Sample Medical Ability to Work Form *(Page 2 of 2)*

(To be completed by attending physician)

Specific functional restrictions and/or limitations

Patient's name _____

Check ☑ only those items that apply in Section A, and provide details in Section B.

Definitions

Restriction: This patient is advised not to perform this activity in any capacity.

Limitation: This patient is able to perform the activity in a reduced capacity. For example, the patient is not able to perform the job with the usual speed, strength or number of repetitions, or for the usual duration.

Section A

	Restriction	Limitation
Physical		
Sitting	☐	☐
Standing	☐	☐
Walking	☐	☐
Lifting	☐	☐
Carrying	☐	☐
Pushing/Pulling	☐	☐
Climbing stairs	☐	☐
Climbing ladders	☐	☐
Climbing scaffolding	☐	☐
Crouching	☐	☐
Crawling	☐	☐
Kneeling	☐	☐
Bending/Twisting/Turning	☐	☐
Repetitive activity	☐	☐
Sustained postures	☐	☐
Gripping	☐	☐
Reaching	☐	☐
Fine dexterity	☐	☐
Balance	☐	☐
Vision/Hearing/Speech	☐	☐
Other *(specify in section B)*	☐	☐

Does patient require medical aids (e.g. splint, brace) or personal protective equipment (e.g. gloves, mask)?

☐ No ☐ Yes *(specify in section B)*

	Restriction	Limitation
Mental		
Thinking/Reasoning	☐	☐
Concentration	☐	☐
Memory	☐	☐
Critical decision-making	☐	☐
Interpersonal contact	☐	☐
Alertness	☐	☐
Other *(specify in section B)*	☐	☐
Environmental		
Exposure to heat/cold	☐	☐
Exposure to dust/fumes/odors	☐	☐
Exposure to chemicals	☐	☐
Food handling	☐	☐
Other *(specify in section B)*	☐	☐
Other		
Shift/attendance duration	☐	☐
Consecutive shift attendance	☐	☐
Shift work	☐	☐
Overtime	☐	☐
Operating vehicle	☐	☐
Operating equipment	☐	☐
Working at heights	☐	☐
Other *(specify in section B)*	☐	☐

Section B

Please provide necessary details about any restrictions or limitations you have identified. Typically, it is not necessary to provide a diagnosis or treatment information.

_____

_____

I have provided this form to the patient named above.

_____ _____

(Physician's signature) (Date)