RETURN-TO-WORK PHYSICAL ASSESSMENT REPORT - CLERICAL

School District No. 85 (Vancouver Island North)
(t) (250) 949-8155 (fax) (250) 949-7496

I authorize the physician, whom I have attended, to release to School District No. 85 Health and Safety and Payroll Departments information requested in the physician's section of this form. School District No. 85 may release the information contained on this form to any third party who has an interest in assessing my medical fitness to return to work and/or entitlement to benefits.

Employee's Name: *(please print)* _____ **Signature:** _____

Name of attending Physician *:(please print)* _____

Physical limitations of injured worker:

Walking:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No walking
- ☐ No walking while holding student

Stairs:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No stairs

Lifting:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No lifting

Speak/ Talk
- ☐ Without restrictions
- ☐ low voice only
- ☐ projected voice
- ☐ Telephone voice
- ☐ No speaking

Work Experience *(swimming/ field trips job shadowing / gym sessions)*
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No _____

Sitting:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No sitting

Standing:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No standing

Carrying:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No carrying

Bending:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No bending
- ☐ No toileting

Push/Pull
- ☐ Some restrictions
- ☐ No pushing
- ☐ No pulling

Sedentary Clerical Work
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No sedentary work

Please specify work restrictions *(as identified above):* _____

_____

_____

Duration of restriction(s): ☐ day(s) ☐ week(s)

Anticipated date able to return to full duties: _____

Worker can rotate between their regular duties for ____ hour(s) and modified work for ____ hour(s) per day to ensure a safe transition to full regular duties.

If suitable employment is available which meets the above-defined restrictions, is this worker capable of returning to work? ☐ Yes ☐ No

Physician: *(Signature)* _____ **Date:** _____

Physician Phone Number: _____ **Physician's Address:** _____