RETURN-TO-WORK PHYSICAL ASSESSMENT REPORT – Custodian

School District No. 85 (Vancouver Island North)
(t) (250) 949-8155 (221) (fax) 250-949-7496

I authorize the physician, whom I have attended, to release to School District No. 85 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
  - ☐ 3+ hrs ☐ 2-3 hrs
  - ☐ 1-2 hrs ☐ 1 hr
  - ☐ less than 1 hr with __ break
- ☐ No walking

Standing:
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ 3+ hrs ☐ 2-3 hrs
  - ☐ 1-2 hrs ☐ 1 hr
  - ☐ less than 1 hr with __ break
- ☐ No standing

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

Ladders:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No ladders

Lifting:
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ Up to 5 lbs.
  - ☐ Up to 10 lbs.
  - ☐ Up to 20 lbs.
- ☐ No lifting

Carrying:
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ Up to 5 lbs.
  - ☐ Up to 10 lbs.
  - ☐ Up to 20 lbs.
- ☐ No carrying

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

Vacuuming:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No vacuuming
- ☐ Back Pac Only
- ☐ No Back Pac

Push/Pull:
- ☐ Without restrictions
- ☐ No pushing
- ☐ No pulling

Sweeping:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No sweeping
- ☐ No side to side sweeping

Dry Mop:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No dry mopping
- ☐ No side to side dry mopping

Repetitive Movements *(arms/wrists/ shoulders/back):*
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ Some restrictions
- ☐ No above shoulder height work
- ☐ No below waist height work
- ☐ No arm extension
- ☐ No repetitive movements

Scrubber:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No scrubber

Wet Mop:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No wet mopping

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

_____

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

Anticipated date able to return to full 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's Address:_____ **Physician Phone Number:**_____