**RETURN-TO-WORK PHYSICAL ASSESSMENT REPORT – Noon Hour Supervisor (or SNNHS)**

**School District No. 85 (Vancouver Island North)**
PO Box 90, Port Hardy BC V0N 2P0 Tel: (250) 949-6618 (Loc. 2225) Fax: 250-949-8792

*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)*** __________________________________________________

***Physician's Section:***
**Please complete form below to describe the physical limitations of the worker**:

**Walking:** ☐ Some Restrictions ☐ Up to 1 hour ☐ 1 hour | ☐ No Restrictions ☐ No Walking on Uneven Surfaces ☐ No Walking
Comments: ___________________________________________________

**Standing:** ☐ Some Restrictions ☐ Up to 1 hour ☐ 1 hour | ☐ No Restrictions ☐ No Standing
Comments: ___________________________________________________

**Sitting:** ☐ Some Restrictions ☐ Up to 1 hour ☐ 1 hour | ☐ No Restrictions ☐ No Sedentary
Comments: ___________________________________________________

**Climbing:** (Stairs/ Slopes) ☐ Some Restrictions (no. of stairs or times per shift) | ☐ No Restrictions ☐ No Climbing
Comments: ___________________________________________________
_____________________________________________________________

**Carrying/ Lifting/ Pushing/ Pulling:** ☐ Some Restrictions ☐ Up to 5 lbs ☐ Up to 10 lbs ☐ Up to 20 lbs | ☐ No Restrictions ☐ No Carrying/Lifting/Pushing/Pulling
Comments: ___________________________________________________
_____________________________________________________________

**Bending:** ☐ Some Restrictions Limit to _____ bends per. ______________ | ☐ No Restrictions ☐ No Bending
Comments: ___________________________________________________
_____________________________________________________________

**Shoulder Movements:** ☐ Some Restrictions ☐ No Restrictions ☐ No Above Shoulder ☐ No Below Waist ☐ No Arm Extension ☐ No Shoulder Movement
Comments: ___________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

Duration of restriction(s): ________ ☐ day(s) ☐ week(s)
Anticipated date able to return to full duties without restrictions: ___________________________

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:**_______________

**Please invoice School District 85 at the address above for the cost of this service.**