UNIVERSITY of GUELPH

HUMAN RESOURCES

OCCUPATIONAL HEALTH AND WELLNESS

Dear University of Guelph Employee;

Regarding your recent workplace injury or illness, Occupational Health, and Wellness (OHW) has prepared the following checklist to use as a tool, to ensure you are able to accomplish your responsibilities in a timely manner.

- ☐ Inform your supervisor of your injury and illness and complete an Incident Report immediately (with your supervisor) and fax to OHW at (519)780-1796 or email ohw@uoguelph.ca
- ☐ Seek medical treatment as needed and inform your supervisor
- ☐ Provide your health care practitioner with a copy of a Workplace Safety and Insurance Board (WSIB) Form 8 **and** the attached letter
- ☐ Return the completed Form 8 to OHW **prior** to your next shift
- ☐ The Workplace Safety and Insurance Act requires that employers, workers, and health care practitioners cooperate in achieving optimal recovery and early and safe return to work. The University will provide you with appropriate modified work, while you are recovering from your injury. Please discuss the option of modified work with your supervisor prior to leaving the workplace, and request a modified work offer in writing
- ☐ OHW and your supervisor will request that you provide updated FAFs (Functional Abilities Forms) during your recovery to understand how your abilities are improving. FAF's are requested to be completed every 14 days by the treating medical practitioner. Your supervisor will continually offer you appropriate modified work reflecting your abilities until you have recovered.

  All medical documents are requested to be uploaded directly to*: The **OHW Secure Drive** or sent via **Secure Fax** to (519) 780-1796.*

Thank you for your cooperation,

Victoria McShannon B.A
WSIB Specialist
Health, Safety and Wellness, Human Resources
University of Guelph
vmcshann@uoguelph.ca
519-824-4120 ext. 56308

UNIVERSITY of GUELPH

HUMAN RESOURCES

OCCUPATIONAL HEALTH AND WELLNESS

Dear Health Care Practitioner;

The University of Guelph has a comprehensive accommodation program, which strives to provide early, safe and appropriate return to work for all employees. We value your assistance in helping us to ensure an optimal recovery of our employee and to provide an appropriate early and safe return to work program.

The success of the return-to-work process depends upon the timely and accurate completed of the Form 8, the Health Professional's Report for work related injuries and/or illness. For occupational mental health claims, please complete Form CMS8 Health Professional's Report for Occupational Mental Stress.

Page Two of the Form 8 or CMS8 will be used only in the purposes of identifying suitable accommodations. We would appreciate receiving as much detailed information as you are able to provide about the worker's abilities. Accommodation will be considered to permit return to work without aggravation to their injury and to facilitate a successful recovery. You will note that the worker is required to sign the bottom of page 2 indicating their consent to release their functional abilities to the employer.

Please provide your patient with the completed form or fax it directly to Occupational Health and Wellness (OHW) via ***Secure Fax*** *to (519) 780-1796.*

If you have any questions, do not hesitate to contact me directly.

Thank you for your cooperation,

Victoria McShannon,
WSIB Specialist
Occupational Health and Wellness
University of Guelph
vmcshann@uoguelph.ca
519-824-4120 ext 56308

wsib ONTARIO

Worker's report of injury/disease (Form 6)

6 Claim number

A. Worker information

Last name	First name	Social Insurance Number

Address (number, street, apt., suite, unit) | Telephone

City/Town | Province | Postal code | Alternate/Cell phone

Job title/Occupation (at the time you were hurt) | Date you started with employer (dd/mm/yy) | How long have you been doing this job for this employer?

Only check if you are one of the following:
☐ executive ☐ elected official ☐ owner ☐ spouse or relative of the employer

Date of birth (dd/mm/yy)

Sex
☐ Male ☐ Female

Your preferred language
☐ English ☐ French ☐ Other .....

Would an interpreter be helpful? ☐ yes ☐ no

Are you a member of a union? ☐ yes ☐ no

Do you authorize your union to represent you in this claim? ☐ yes ☐ no

If yes, do you consent to the disclosure of verbal claim file status information to your union representative? ☐ yes ☐ no

Provide your union name and local

B. Employer information

Company/Employer name

Address

City/Town | Province | Postal code

Your immediate supervisor's name | Company telephone

C. Accident/illness dates and details

1. Date and hour of accident/Awareness of illness (dd/mm/yy)
☐ AM ☐ PM

Date and hour reported to employer (dd/mm/yy)
☐ AM ☐ PM

2. Who did you report this accident/illness to? (name and position)

Telephone

3. Area of injury (body part) - (please check all that apply)

			Left	Right	Left	Right	Left	Right	Left	Right
☐ Head	☐ Teeth	☐ Upper back	☐ Shoulder	☐	☐ Wrist	☐	☐ Hip	☐	☐ Ankle	☐
☐ Face	☐ Neck	☐ Lower back	☐ Arm	☐	☐ Hand	☐	☐ Thigh	☐	☐ Foot	☐
☐ Eye(s)	☐ Chest	☐ Abdomen	☐ Elbow	☐	☐ Finger(s)	☐	☐ Knee	☐	☐ Toe(s)	☐
☐ Ear(s)		☐ Pelvis	☐ Forearm	☐			☐ Lower leg	☐		

☐ Other: .....

Are you: ☐ Left handed ☐ Right handed

4. Did the accident/illness happen on the employer's property or work site? ☐ yes ☐ no

Specify where it happened (shop floor, warehouse, client/customer site, parking lot, etc.):

5. Did it happen outside the Province of Ontario? ☐ yes ☐ no

If yes, indicate where (city, province/state, country):

6. Have you hurt this area(s) of your body before? ☐ yes ☐ no

7. Do you have any prior related WSIB/WCB claims?
☐ no ☐ yes - in Ontario ☐ yes - outside Ontario

Contact accessibility@wsib.on.ca if you require this communication in an alternative format.

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Claim number

Last name	First name	Social Insurance Number

C. Accident/illness dates and details (continued)

8. If you had a sudden type of accident/illness, describe your injury and what happened to cause it (e.g. hurt lower back while lifting a 50 pound box, sprained left ankle when I slipped on a wet floor, used a new cleaner and immediately got a rash). Please indicate the size, weights and names of any objects involved.

or

If you had a gradual onset type of injury, describe your injury, the work that you do and what you believe caused your injury/condition.

9. When did you first start to have problems with this injury/condition?

10. If you did not report this to your employer right away, please tell us the reason why.

11. If there were any witnesses to your accident, or if you mentioned your pain or problems to your supervisor or any of your co-workers, give us their names and positions.

	Name	Position
1		
2		

12. The Workplace Safety and Insurance Act requires your employer to give you a copy of the Employer's Report of Injury/Disease (Form 7).

Did you receive a copy of the Form 7? ☐ yes ☐ no

The Workplace Safety and Insurance Act requires you to give a copy of this report (Worker's Report of Injury/Disease - Form 6) to your employer

D. Health care information - Give your health professional your WSIB claim number

1. Did you get first aid or care at work? ☐ yes ☐ no	If yes, when (dd/mm/yy)	and by whom (name):

2. Where did you go for health care, for your injury, outside of work? (check all that apply)

	Facility/Hospital (name and address)		Date of visit (dd/mm/yy)
☐ Nursing Station		☐ Ambulance	
☐ Emergency Department		☐ Health professional office	
☐ Admitted to hospital	Date of visit (dd/mm/yy)	☐ Clinic	

3. Were you prescribed any medications/drugs? ☐ yes ☐ no	4. Were you referred for any other treatment or tests? ☐ yes ☐ no
5. Did you talk to your health professional about going back to regular or modified work? ☐ yes ☐ no	If yes, were you given any work limitations? ☐ yes ☐ no

6. Did you tell your employer you went for medical treatment? ☐ yes ☐ no **If no, please tell your employer right away.**

If yes, when? (dd/mm/yy)	and to whom (name and position):

wsib ONTARIO | wsib.ca

Claim number

Last name	First name	Social Insurance Number

E. Lost time and return to work

1. After the day of accident/illness:

☐ I returned to work to my **regular job** and **did not** lose any time or pay.

☐ I returned to **modified duties** and **did not** lose any time or pay.

☐ **I lost time and/or pay** (e.g. regular pay, shift differential, bonuses, premiums, etc.).

Date you first lost time and/or pay (dd/mm/yy)

2. If you lost time, have you returned to work? ☐ yes ☐ no

If **yes**, date of your return to work (dd/mm/yy) ☐ Regular work ☐ Modified work

If **no**, did you discuss return to work with your employer? ☐ yes ☐ no

Does your employer have modified work? ☐ yes ☐ no

F. Earnings (do not include overtime here)

1. Rate of pay

$ ..... per ☐ hour ☐ week ☐ other .....

2. Usual number of pay hours

..... per ☐ week ☐ other .....

3. If you lost time from work after the day of accident/illness, did your employer continue to pay you? ☐ yes ☐ no

4. Have you applied for, or did you receive, any other benefits (money) while off work (e.g. EI benefits, sick benefits, social services, insurance, etc.)? ☐ yes ☐ no

5. At the time of the accident/illness did you work for more than one employer? ☐ yes ☐ no

G. Declarations and signature

By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related injury or disease. I am also authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board with information about my functional abilities on the WSIB's "Functional Abilities Form for Planning Early and Safe Return to Work".

It is an offence to deliberately make false statements to the Workplace Safety and Insurance Board. I declare that all of the information provided on pages 1, 2 and 3 is true.

Signature (print, sign and return to the WSIB or type and upload)	Date (dd/mm/yy)

If you are under the age of 16, your parent or guardian, must authorize the release of the functional abilities information.

Signature	Relationship	Date (dd/mm/yy)	Telephone

Personal information about you will be collected throughout your claim under the authority of the *Workplace Safety and Insurance Act*, 1997. Your personal information will be used to administer your claim(s) and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, Canada Revenue Agency (CRA), and others as required. Your Social Insurance Number is used to register claims, identify workers and to issue income tax statements and is collected under the authority of the *Income Tax Act*. Information may only be disclosed to the employer, external medical consultants, external service providers, researchers, third parties for cost recovery purposes and others as authorized by the *Workplace Safety and Insurance Act* and the *Freedom of Information and Protection of Privacy Act*. Your name and telephone number may be disclosed to third parties conducting satisfaction surveys and focus groups. Incoming and outgoing calls may be recorded for quality assurance purposes. Questions about this collection should be directed to the decision maker responsible for your file or by calling 1-800-387-0750

You can find a more detailed privacy statement at wsib.ca or by calling toll-free at 1-800-387-0750.

Upload form and supporting documents online at wsib.ca/upload.

Claim number

Last name	First name	Social Insurance Number

H. Additional information

Health Professional's Report (Form 8)

Health Professional, please use this form for:

- Patients who are claiming benefits under the WSIB insurance plan for an injury/illness related to work, or
- You think that the cause of your patient's injury/illness is workplace factors.

Section 37 of the *Workplace Safety and Insurance Act, 1997* provides the legal authority for health professionals, hospitals and health facilities to submit, without consent, information relating to a worker claiming benefits to the Workplace Safety and Insurance Board (WSIB).

Completing the form:

- **Give a copy of page two only to your patient to give to employer.**
- **Please send pages one and two to the Workplace Safety and Insurance Board.**
- **On the worker's initial visit, ONLY the Form 8 will be paid. A Functional Abilities Form (FAF) will not be paid if completed on the same date.**

For Electronic Submission

To register for electronic form submission and electronic billing, please go to www.telushealth.com/wsib or call Telus at 1-866-240-7492 for more information.

By Fax to:

416-344-4684 or 1-888-313-7373

Or by Mail to:

Workplace Safety and Insurance Board
200 Front Street West
Toronto, ON M5V 3J1

wsib
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ONTARIO

www.wsib.on.ca

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Fax To:
416-344-4684
OR 1-888-313-7373

Claim Number (If known)

Start >

8 Health Professional's Report (Form 8)

A. Patient and Employer Information - (Patient to complete Section A)

Last Name	First Name	Init.	Sex
			☐ M ☐ F

Address (no., street, apt.)	City/Town	Prov.	Postal Code
		ON	

Telephone	Social Insurance No.	Date of Birth (dd mm yyyy)	Language
			☐ Eng. ☐ Fr. ☐ Other

Employer Name

The Workplace Safety and Insurance Board (WSIB) collects your information to administer and enforce the Workplace Safety and Insurance Act. The Social Insurance Number may be used to identify workers and to issue income tax information statements as authorized by the Income Tax Act. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-0750.

B. Incident Dates and Details Section

1. How did the injury/reinjury or illness occur at work?

Occupation

Date of incident/or when did the symptoms start? dd mm yyyy

C. Clinical Information Section - (Please check all that apply)

1. Area of Injury/Illness

☐ Brain
☐ Head
☐ Face
☐ Eyes
☐ Other: _____

☐ Ears
☐ Teeth
☐ Neck
☐ Chest

☐ **Upper back**
☐ **Lower back**
☐ Abdomen
☐ Pelvis

Left		Right
☐	**Shoulder**	☐
☐	Arm	☐
☐	Elbow	☐
☐	Forearm	☐

Left		Right
☐	Wrist	☐
☐	Hand	☐
☐	Fingers	☐

Left		Right
☐	Hip	☐
☐	Thigh	☐
☐	Knee	☐
☐	Lower Leg	☐

Left		Right
☐	Ankle	☐
☐	Foot	☐
☐	Toes	☐

2. Description of Injury/Illness Physical Examination Findings

☐ Pain at rest/Night Pain

Pain Rating Scale

0 1 2 3 4 5 6 7 8 9 10

☐ Abrasion
☐ Amputation
☐ Bite
☐ Burn
☐ Contusion/Hematoma/Swelling
☐ Crush Injury

☐ Disc Herniation
☐ Dislocation
☐ **Fall from Height**
☐ Foreign Body
☐ **Fracture**
☐ Hernia
☐ Infection

☐ Inflammation
☐ Internal Joint Derangement
☐ Joint Effusion
☐ Laceration
☐ **Neurological Dysfunction**
☐ Psychological
☐ Puncture (non-needlestick)

☐ Repetitive Strain Injury
☐ Spinal Cord Injury
☐ Sprain/Strain
☐ **Surgical Intervention**
☐ Tendonitis/Tenosynovitis
☐ ▼ Range of Motion

☐ Other _____

Exposure/Illness

☐ Asthma
☐ Cancer
☐ Fumes - Inhalation
☐ Hand-arm Vibration
☐ Hearing Loss
☐ Infectious Disease
☐ Needle Stick
☐ Poisoning/Toxic Effects
☐ Skin Condition

3. Are you aware of any pre-existing or other conditions/factors that may impact recovery? ☐ yes ☐ no

If yes, describe _____

4. Diagnosis

D. Treatment Plan

1. What is the treatment plan (type of treatment, duration) including prescribed medications?

2. To be completed by physicians only.

Work Injury/Illness Medications	Dose	Frequency	Duration	Work Injury/Illness Medications	Dose	Frequency	Duration
1.				**3.**			
2.				**4.**			

3. Investigations & Referrals:

☐ None ☐ Labs ☐ Xrays ☐ CT Scan ☐ MRI ☐ EMG ☐ Ultrasound ☐ Other _____

☐ FP/GP
☐ Specialist/ Specialty _____
☐ Chiropractor

☐ Occupational Health Centre
☐ Occupational Therapist
☐ Other _____

☐ Physiotherapist
☐ Psychologist

Would the patient benefit from the following referrals?
☐ Specialty Clinic
☐ Regional Evaluation Centre (REC)

Name of Referral or Facility (if known) | Telephone | Appointment Date (dd mm yyyy)

E. Billing Section

Health Professional Designation
☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class)

Service Code **8M** | WSIB Provider ID

HST Registration No.	HST Amount Billed (if applicable)	Service Code	Your Invoice No.	Service Date (dd mm yyyy)
	$	ONHST		

Health Professional Name (please print) | Address

Telephone | Fax

wsib cspaat ONTARIO

Claim Number (If known)

8 Health Professional's Report (Form 8)

Return To Work Information

Once completed, please ensure that a copy of this page only is provided to the worker.

Last Name	First Name	Init.	Birth Date dd mm yyyy

Area(s) of Injury(ies)/Illness(es)

Date of Incident dd mm yyyy

F. Return To Work Information - Must be completed by a Health Professional

When work injury/illness occurs, focus on return to usual activity including return to safe and appropriate work is best practice. Most workers who experience soft tissue injury are able to remain at work.

1. Have you discussed return to work with your patient? ☐ yes ☐ no

2. ☐ **This worker can resume Regular duties. Start date** dd mm yyyy **If graduated hours required please specify** _____

☐ **This worker can begin Modified duties. Start date** dd mm yyyy **If graduated hours required please specify** _____

☐ **This worker is not able to work because of the workplace injury/illness.**

Please provide explanation _____

3. Please indicate the worker's status and functional abilities in relation to the workplace injury and diagnosis.

A. Full Functional Abilities ☐

B. Worker Functional Abilities

	Able to	Not Able to		Able to	Not Able to		Able to	Not Able to
Bend/Twist	☐	☐	Operate Heavy Equipment	☐	☐	Stand	☐	☐
Climb	☐	☐	Operate a Motor Vehicle	☐	☐	Use of Public Transportation	☐	☐
Kneel	☐	☐	Push/Pull	☐	☐	Use of Upper Extremities	☐	☐
Lift	☐	☐	Sit	☐	☐	Walk	☐	☐

C. Other Limitations: eg. Environmental Conditions, Medication, Use of Protective Equipment.

Please describe: _____

4. From the date of this assessment, the above limitations will apply for approximately:

☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Follow-up Appointment

☐ None required ☐ As Needed Date of next appointment dd mm yyyy

Health Professional's Name (Please print)	Address	
Health Professional's Signature PLEASE PRINT AND SIGN	Telephone	Service Date dd mm yyyy

G. Worker's Signature

By signing below I am authorizing the above noted health professional, who is treating me, to provide my employer with a copy of this page outlining my functional abilities. I understand a copy will be sent to the Workplace Safety and Insurance Board (WSIB) by my health professional.

Signature	Date dd mm yyyy
PLEASE PRINT AND SIGN	

Once completed, please ensure that a copy of this page only is provided to the worker.

print reset save

Functional Abilities Form

for Planning Early and Safe Return to Work

Health Professionals, please use this form ONLY when requested by an employer or worker.

The purpose of this form is to identify your patient's overall functional abilities and work restrictions that will assist his/her return to suitable work.

Please promptly complete and return pages 2 and 3 of this form to the worker or employer to assist the workplace parties in planning an early and safe return to work.

PLEASE ENSURE YOUR BILLING INFORMATION IS NOT GIVEN TO THE WORKER OR EMPLOYER.

Authority to Release Information

Section 37(3) of the *Workplace Safety and Insurance Act, 1997* provides the legal authority for health professionals to give the Workplace Safety and Insurance Board (WSIB), the injured worker and the employer such information as may be prescribed concerning the worker's functional abilities.

When completing this report, please **print** in **black ink**.

Worker and/or employer should complete Sections A and B of this report. If your patient needs assistance, please help. Please submit this report even if Section A is not fully completed.

Information about your responsibilities can be found on **Page 4**.

The WSIB will pay health professionals for completing this form.

Mail to:
Workplace Safety and Insurance Board
200 Front Street West
Toronto, ON M5V 3J1

OR

Fax to:
416-344-4684
or 1-888-313-7373

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...go to form

A guide to completing this form is available at www.wsib.on.ca

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Mail to:
200 Front Street West
Toronto ON M5V 3J1

or Fax to:
416 344-4684
OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

Claim No.

Start >

A. Section A to be completed by the employer and/or worker.

Worker's Last Name	First Name	Telephone

Address (no., street, apt.)	City/Town	Province	Postal Code

Employer's Name

Full Address (No., Street, Apt.)

City/Town | Prov. | Postal Code

Date of Birth (dd/mm/yyyy)

Date of Accident/ Awareness of Illness (dd/mm/yyyy)

Employer Telephone

Employer Fax No.

fold fold

1. Type of job at time of accident (where available, please attach description of job activities)

Area(s) of injury(ies)/illness(es)

2. Have the worker and the employer discussed Return To Work ☐ yes ☐ no

If no, will be discussed on dd mm yyyy

3. Employer contact name

Position

B. Worker's Signature

By signing below, I am authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board (WSIB) with information about my functional abilities on the WSIB's "Functional Abilities for Planning Early and Safe Return to Work" form.

Signature *Type your name and upload, or print and sign before returning to WSIB.*

Date dd mm yyyy

C. Health Professional's Billing Information
For billing purposes fax or mail pages 2 and 3 to the WSIB.

Health Professional's Designation

☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class) ☐ Other

PROVIDER BILLING INFORMATION IN THE BOLDED AREA OF SECTION C SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER.

Are you registered with the WSIB?

☐ yes Please enter the **WSIB Provider ID.** in the box provided

☐ no Please call **1 - 800-569-7919** to register

WSIB Provider ID.

Your Invoice Number

Service Code **FAF**

▼ Complete these fields if **HST** is applicable to this form ▼

HST Registration Number	Service Code	HST Amount Billed
	ONHST	**$** .

Health Professional's Name (please print)

Address (No. Street, Apt.)

City/Town	Province	Postal Code	Fax

I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation to the WSIB.

Health Professional's Signature	Telephone	Date
Type your name and upload, or print and sign before returning to WSIB.		dd mm yyyy

...go to next page

wsib ONTARIO

Mail to:
200 Front Street West
Toronto ON M5V 3J1

or Fax to:
416 344-4684
OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

Worker's Last Name	First Name	Claim No.

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment dd mm yyyy

Start >

2. Please check one:

- ☐ Patient is capable of returning to work with **no restrictions.**
- ☐ Patient is capable of returning to work **with restrictions.** Complete sections **E and F.**
- ☐ Patient is physically unable to return to work at this time. Complete section **F.**

E. Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Lifting from waist to shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

Ladder climbing:
- ☐ Full abilities
- ☐ 1 - 3 steps
- ☐ 4 - 6 steps
- ☐ Other (please specify)

Travel to work:

Ability to use public transit	Ability to drive a car
☐ yes	☐ yes
☐ no	☐ no

2. Please indicate **Restrictions** that apply. Include additional details in section 3

- ☐ Bending/twisting repetitive movement of (please specify)
- ☐ Work at or above shoulder activity:
- ☐ Chemical exposure to:
- ☐ Environmental exposure to: (e.g. heat, cold, noise or scents)
- ☐ Limited use of hand(s):

Left		Right
☐	Gripping	☐
☐	Pinching	☐
☐	Other (please specify)	☐

- ☐ Limited pushing/pulling with:
  - ☐ Left arm
  - ☐ Right arm
  - ☐ Other (please specify)
- ☐ Operating motorized equipment: (e.g. forklift)
- ☐ Potential side effects from medications (please specify) Do not include names of medications.
- ☐ Exposure to vibration:
  - ☐ Whole body
  - ☐ Hand/Arm

3. Additional Comments on **Abilities and/or Restrictions**.

4. From the date of this assessment, the above will apply for approximately:
☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Have you discussed return to work with your patient? ☐ yes ☐ no

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours

Start Date dd mm yyyy

F. Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions**. dd mm yyyy

I have provided this completed Functional Abilities Form to: ☐ **Worker** **and/or** ☐ **Employer**

...go to next page

print reset save

Important Information

To receive benefits, the worker must apply for benefits within six months of the date of a work-related injury or illness. When filing a claim for benefits, the worker must also consent to the disclosure of functional abilities information provided by a health professional to his or her employer for the purpose of facilitating an early and safe return to work. Failure to file a claim or provide consent for the release of the functional abilities information can result in no benefits.

If you have questions about the completion of this form please call 1-800-387-0750.

Worker's Responsibilities

- This form is to be completed by a treating health professional, who will discuss the information with you.
- Once completed, contact your employer **immediately** to review the information on the completed form. Together, you and your employer will begin to plan an early and safe return to work.

Employer's Responsibilities

- This form provides general information about this worker's functional abilities and restrictions to help you plan an early and safe return to work.
- When you provide this form to the treating health professional, ensure that you have the worker's signed consent (Section B) for the release of functional abilities information.
- Where available, also attach a description of the worker's job activities to assist the health professional in completing the form.
- The prescribed form that is available from the WSIB is a generic form developed to assist with general functional abilities information.
- The WSIB will pay the health professional to complete the prescribed WSIB form only. A charge will appear on your Accident Cost statement or Schedule 2 Invoice which reflects the cost of payment for each form completed.
- If you have a form that is specific to your workplace and have the cooperation of the worker in providing consent for the release of information on your form, you may use your own form. If you create your own form, you must reimburse the health professional directly.
- Do not send a copy of the completed Functional Abilities Form for Planning Early and Safe Return to Work to the WSIB. The health professional is responsible for submission of the form.

Health Professional's Responsibilities

- The employer and worker will use this information to plan the worker's early and safe return to work.
- Their return to work plans will reflect the functional abilities and restrictions you have noted and presume that no clinical contraindications exist for other work activities, therefore it is crucial that all sections be completed in full.
- The completion of this form is based on your examination of the worker and does not require a specialized functional abilities evaluation.
- Diagnostic or confidential information **must not** be included.
- Please add specific information on the duration of temporary restrictions or maximum times or weights to be considered, in section **E3** under **abilities and/or restrictions**. If necessary, attach an additional page to this completed form to describe abilities and restrictions.
- **Completion of this form does not replace clinical reporting requirements to the WSIB**.
- **Once you have received this form, promptly complete it and give it to the worker and/or employer.**
- **For billing purposes fax or mail pages 2 and 3 to the WSIB. When faxing, do not mail a copy.**

The WSIB will pay the health professional for the completed form when pages 2 and 3 are received.

Workplace Safety and Insurance Board
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or 1-888-313-7373

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