FITNESS FOR WORK FORM

- GNB has alternate/modified work programs to assist employees to return to work after an injury or illness or to be accommodated if the condition is long term or permanent in nature
- Accommodation Requests will be reviewed by GNB on an individual basis depending on the employee's specific needs and job requirements.
- The cost associated with the completion of this form is the responsibility of the employee/patient. Please direct bill the patient.
- Any additional inquires requested by the employer will be the responsibility of the employer.

EMPLOYEE/EMPLOYER SECTION

Employee Name / Employee Number		Job Title **(attach job description)**	
Department / Facility	☐ Full-time ☐ Part-time ☐ Casual ☐ Temporary	Bi-weekly Guaranteed Hours: _______________	Last Day Worked

EMPLOYEE CONSENT	
I hereby authorize and request my treating physician to complete this form and release information concerning my medical employment limitations for the purpose of assisting my employer in determining appropriate and safe return to work or accommodation options.	
Employee Signature:	**Date:**

Please return the completed form to the Disability Management Designate responsible for this file:		
	Tel:	**Fax:**

PHYSICIAN: (complete the following sections)

Date patient assessed:	First date unable to work:	
Is this health issue:	☐ work related ☐ non-occupational	☐ acute ☐ recurring ☐ chronic

GNB promotes Modified or Alternate job duties to support employees to remain at the workplace, where possible:

Please indicate if this is an option to consider for your patient while recovering from an illness and/or injury:

☐ Yes Complete limitations section of this form for the facilitation a "stay at work" program.

☐ No Not at this time, to be considered by physician at next assessment

FITNESS FOR WORK FORM

Patient is:

☐ Fit to return to own job

☐ Fit to return to work with limitations or to alternate/modified duties
☐ Not able to return to work at this time
If unable to return to work, please indicate anticipated duration of absence:
______ days ☐ 1-2 weeks ☐ 2-3 weeks ☐ 3-4 weeks ☐ 4-6 weeks ☐ 6-12 weeks ☐ > 12 weeks

Is full recovery expected? ☐ Yes ☐ No ☐ Unknown at present

Date of next assessment:	**Expected return to work date**:
______________________________	______________________________

MEDICAL EMPLOYMENT LIMITATIONS

Restriction: Patient advised not to perform this activity in any capacity **Limitation: Patients able to perform the activity in a reduced capacity**	**All limitations and/or restrictions must be quantified below**

PHYSICAL	**Restriction NO**	**Restriction YES**	**Limitation NO**	**Limitation YES**	**ENVIRONMENTAL**	**Restriction**	**Limitation**
Sitting	☐	☐	☐	☐	Exposure to heat/cold	☐	☐
Standing	☐	☐	☐	☐	Exposure to dust/fumes/odors	☐	☐
Walking	☐	☐	☐	☐	Exposure to chemicals	☐	☐
Squatting	☐	☐	☐	☐	Exposure to foods	☐	☐
Kneeling	☐	☐	☐	☐	**OTHER**	**Restriction**	**Limitation**
Reaching (forward)	☐	☐	☐	☐	Shift Attendance/Duration	☐	☐
Reaching (overhead)	☐	☐	☐	☐	Consecutive Shifts	☐	☐
Lifting	☐	☐	☐	☐	Shift Work	☐	☐
Carrying	☐	☐	☐	☐	Operating a vehicle	☐	☐
Pushing/Pulling	☐	☐	☐	☐	Noise Exposure	☐	☐
Bending/Twisting	☐	☐	☐	☐	Visual Limitation	☐	☐

➢ **Please provide quantitative details regarding medical employment limitations indicated above – i.e. maximum weight, frequency**

____
____
____
____
____

FITNESS FOR WORK FORM

PSYCHOLOGICAL / COGNITIVE Limitations (if applicable- PHYSICIAN TO COMPLETE this section)	
☐ Difficulty with detailed/complex tasks	☐ Difficulty with recalling instructions
☐ Difficulty with multitasking	☐ Difficulty learning new tasks
☐ Easily distracted, limited focus	☐ Difficulty with managing time
☐ Difficulty dealing with public	☐ Difficulty reasoning/problem solving
☐ Difficulty coping with stressors	☐ Difficulty with critical decision making
☐ Difficulty dealing with confrontational issues	☐ Cognitive fatigue

Please advise if limitation(s)/restriction(s) are ☐ temporary or ☐ permanent.
If temporary, please indicate duration (maximum 3 months before next assessment):

____

DAY/MONTH/YEAR --Date restrictions end

Is the patient taking any medication which might impair his/her ability to do their job safely? ☐ Yes ☐ No
If yes, please comment:

GNB promotes employee participation in **GRADUAL return to work program** is required for safe return to work, please indicate progression (i.e. hours per day over period of time or sooner if tolerated):
Week 1 ____
Week 2____
Week 3____
Week 4____

Other Comments:

Physician Name:

Physician Signature:	Date:
We appreciate your feedback , If you have any questions or require clarity, please contact GNB contact	Contact Information: