RETURN-TO-WORK PHYSICAL ASSESSMENT REPORT – BUS DRIVER

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

I authorize the physician, whom I have attended, to release to School District No. 85 Transportation 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

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

Lifting:
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ 0 – 10 lbs
  - ☐ 11 – 20 lbs
  - ☐ 21 – 50 lbs
- ☐ No lifting

Clean Bus
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ Crouching
  - ☐ Washing Bus
  - ☐ Sweep Bus
  - ☐ Garbage

Driving
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ Automatic only
- ☐ paved road only
- ☐ air seat only

Sitting:
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ 5 – 30 mins.
  - ☐ 30 – 60 mins.
  - ☐ 1 – 2 hrs.
- ☐ No sitting

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

Carrying:
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ 0 – 10 lbs
  - ☐ 11 – 20 lbs
  - ☐ 21 – 50 lbs
- ☐ No carrying

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

Push/Pull
- ☐ Some restrictions
- ☐ No pushing
  L. Hand __ R. Hand __
- ☐ No pulling
  L. Hand __ R. Hand__
- ☐ Max. Weight____ lbs.

Arm/ Shoulder Work
Left Arm___ Right Arm___
Left Shoulder__ Right Shoulder__
- ☐ Without restrictions
- ☐ Some restrictions
- No above shoulder work
- No over head work
- No arm/ shoulder work

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

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Anticipated date able to return to full duties:____

Physician: *(Signature)* ________________________ **Date:** ____________________________

Physician Phone Number:________________ Physician's Address:_____________________