

RETURN-TO-WORK PHYSICAL ASSESSMENT REPORT - CLERICAL

School District No. 85 (Vancouver Island
North) (t) (250) 949-6618 (fax) (250) 949-8792

I authorize the physician, whom I have attended, to release to School District No. 85 Health and Safety 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
 No walking while holding student

Stairs: Without restrictions
 Some restrictions
 No stairs

Lifting: Without restrictions
 Some restrictions
 No lifting

Speak/ Talk Without restrictions
 low voice only
 projected voice
 Telephone voice
 No speaking

Work Experience Without restrictions
 Some restrictions
 No _____
(swimming/ field trips / job shadowing / gym sessions)

Sitting: Without restrictions
 Some restrictions
 No sitting

Standing: Without restrictions
 Some restrictions
 No standing

Carrying: Without restrictions
 Some restrictions
 No carrying

Bending: Without restrictions
 Some restrictions
 No bending
 No toileting

Push/Pull Some restrictions
 No pushing
 No pulling

Sedentary Clerical Work Without restrictions
 Some restrictions
 No sedentary work

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

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

Anticipated date able to return to full duties: _____

Worker can rotate between their regular duties for ____ hour(s) and modified work for ____ hour(s) per day to ensure a safe transition to full regular 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 Phone Number: _____ **Physician's Address:** _____