RETURN-TO-WORK PHYSICAL ASSESSMENT REPORT – General

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

Other duties *(swimming/ field trips gym sessions)*
- ☐ Without restrictions
- ☐ No _____

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 (Desk) 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:_____

Physician: *(Signature)* _____ **Date:** _____

Physician Phone Number:_____ **Physician's Address:**_____