RETURN-TO-WORK PHYSICAL ASSESSMENT REPORT - MAINTENANCE

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

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

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

Lifting:
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ 0 – 10 lbs
  - ☐ 11 – 25 lbs
  - ☐ 25 – 50 lbs
- ☐ No lifting

Use of Tools
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ Hammer work
  - ☐ Skill Saw
  - ☐ Table Saw
  - ☐ Hand Drills
- ☐ No Tools

Work Experience *(Ladders, Scaffolding, Operating Man-lift or forklift, Bricklaying,)*
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No

_____

Sitting:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No sitting

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

Carrying:
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ 0 – 10 lbs
  - ☐ 11 – 25 lbs
  - ☐ 25 – 50 lbs
- ☐ No carrying

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

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

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

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

_____

_____

Anticipated date able to return to full duties:_____

If suitable employment is available which meets the above-defined restrictions, is this worker capable of returning to work? ☐Yes ☐No Duration of restriction(s): ☐ day(s) ☐ week(s)

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

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