University of Lethbridge

University of Lethbridge – Wellness and Recognition
Managed Care Program
Fitness for Work Form

Phone: 403-332-5217 or 403-382-7187 Confidential fax: 403-329-2685

To be Completed by Employee		
Name:	ID#:	Date of Birth:
Job Title:	Work Location: ☐ Lethbridge ☐ Calgary	
Home Phone or Cell #:	Email address:	
First day off work:		
Is this an: ☐ illness ☐ or injury?	Is this work related: ☐ Yes ☐ No	
This information is being collected under the authority of Section 33(c) of the Alberta Freedom of Information and Protection of Privacy Act (FOIP), will be used for the purpose of determining your fitness to return to work and payroll and benefit administration, and is protected by the privacy provisions of FOIP. If you require further information regarding the collection and use of this information, contact Employee Wellness at (403) 332-5217 or (403)-382-7187. **If there is a fee for completing this form, your physician can send an invoice to U of L Wellness and Recognition, Attn: Manager, Wellness and Recognition, 4401 University Dr. Lethbridge, AB T1K3M4 or fax to (403)329-2685.** Employee Signature: Date:		

Dear Physician,
Consistent with the Canadian Medical Association Policy on return to work, we agree that work is normal and the absence from the workplace is detrimental to an individual's mental, physical, and social well-being. The University of Lethbridge's Managed Care program is designed to help employees remain or return to work safely and at the earliest opportunity, using appropriate modified work alternatives when required, while preserving confidentiality of medical information.

To Be Completed by Physician		
Is this health issue: ☐ Work Related ☐ Non-Occupational		
Date illness began or onset of symptoms:	Date of first visit for this absence:	Date of next appointment:
Primary nature of illness/disability:		
Do co-morbid conditions exist? ☐ (If yes, please indicate details in limitations section.)		
Prognosis:		
Has a treatment plan been recommended or prescribed? ☐ Yes ☐ No		
Is patient compliant with treatment plan? ☐ Yes ☐ No		
Is the Patient:		
Fit to return to work to own job? ☐ Yes ☐ No		
Fit to return to work with limitations or fit for modified/alternate work/hours with limitations identified below: ☐ Yes ☐ No		

Please indicate physical and non-physical limitations/restrictions:

Is the patient able to perform physical work at any of the following levels: (Please check one)?
☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

Shoulder/Arm/Forearm Movements: ☐ No work above shoulder height ☐ Limited reaching with left/right arm ☐ Limited pushing/pulling with left/right arm Hand Movements: ☐ Limited dexterity left/right hand ☐ Limited forceful grip/grasp with left/right hand ☐ No use of left/right hand ☐ Limited keyboarding/telephone work Lifting Weight: ☐ No lifting floor to waist > _____ lbs ☐ No lifting waist to shoulder > _____ lbs ☐ No lifting above shoulder > _____ lbs ☐ No lifting at all Lower Extremity Movements: ☐ Walking limited to: _____ ☐ Standing limited to: _____ ☐ Squat/knee limited to: _____ ☐ No job that requires stair climbing ☐ No climbing ladders Vision: ☐ Seeing or recognizing visual cues including body language and facial expressions_____	Back Movements: ☐ Limited twisting/bending at waist ☐ Limited sitting ☐ Limited Range of Motion of neck Respiratory Exposure: ☐ No exposure to heat/cold ☐ No direct exposure to smoke, dust, mist, odors ☐ No exposure to solvents, petroleum distillates, etc. Cognitive/Psychological: ☐ Problems maintaining focus/concentration ☐ Reduced energy and pace required for the job ☐ Reduced memory ☐ Difficulty with interpersonal contact ☐ Difficulties performing simple and repetitive tasks ☐ Difficulties performing critical decision making Personal Protective Equipment: ☐ Type _____ Ergonomic Assessment: ☐ Work Area _____ ☐ Specific equipment _____ ☐ Other: _____

Additional and/or specific limitations/restrictions or accommodations required (hours of work, graduated return to work schedule):

Will the patient require time off during the return to work plan to attend treatment plan appointments? If yes provide details:

Is complete recovery expected?	Estimated Return to Work Date:	Duration of Restrictions:
☐ Yes ☐ No ☐ Unknown		

Please provide necessary details about any restrictions or limitations you have identified. Typically it is not necessary to provide a diagnosis.

Is a follow up assessment required? ☐
If Yes, appointment date:

Physician Name:	**Mailing Address:**
Physician Signature:	**Date:**