

Functional Abilities Form

To be completed by attending Medical Practitioner



**BC FOOD PROCESSORS
HEALTH & SAFETY COUNCIL**

"Safety ^{SR} Every Step of the Way"

Worker's Signature: I am authorizing any health professional who treats me to provide my employer, WorkSafeBC and me with any relevant medical information. I understand that this information will be treated as confidential and will be used only in the management of this injury or subsequent WorkSafeBC claims.

Employee Name

Employee's Signature

Date

Injury Date:

Work Related Injury

Non- Work Related Injury

Medical Practitioner's Description of Injury:

Physical limitations of injured worker (please check all that apply)

Walking:

- Without limitations
 Some limitation (Please Specify)*

Standing:

- Without limitations
 Some limitations (Please Specify)*

Lifting:

- Without limitations
 Some limitations (Please Specify)*

Carrying:

- Without limitations
 Some limitations (Please specify)*

Sitting:

- Without limitations
 Some limitations (Please Specify)*

Bending:

- Without limitations
 Some limitations (Please Specify)*

Repetitive movements (arm/wrist):

- Without limitations
 Some limitations (Please Specify)*

Comments:

Recommendation for work hours:

- Full-Time Modified Hours (Please Specify) Regular Shift

Graduated Hours (Please Specify)

*Complete limitations to be in effect until (M/D/YY)

*Estimated date of return to duties with *some limitations (M/D/YY)

*Complete recovery expected?

Yes

No

Date to be reassessed (M/D/YY):

or immediately

Name and phone number of attending medical practitioner (Please print and provide stamp if possible)

**If a fee is required for completion please (insert organization billing protocol)