OCCUPATIONAL HEALTH ASSESSMENT FORM

TO ALL EMPLOYEES:
Please return this completed form to your supervisor within 24 hours of being away from work due to accident or illness, and/or prior to the start of your next scheduled shift.

AUTHORIZATION TO RELEASE INFORMATION

I understand that modified or alternate duties are available at Pembina Trails School Division to assist with my return to work. I authorize my doctor, to release information to Pembina Trails School Division concerning my functional capabilities and/or limitations and restrictions. I give permission for Human Resources to contact my Health Care Provider to discuss or clarify information obtained on this form and /or return to work.

Employee Name (please print)	Employee Signature	Date (mm/dd/yyyy)

ATTENDING PHYSICIAN (Please complete in full, including restrictions & capabilities section):
Please ensure the above authorization is signed before completing the following information. This will assist Pembina Trails School Division in providing the earliest, safest, meaningful, and productive return to work possible for this employee.

1. On the basis of my examination on _____, 20____, this employee:
   a) is able to return to regular work duties? □ Yes □ No
   b) is able to work normal scheduled hours? □ Yes □ No Reduced Hours Please Specify: _____

2. Indicate the location of the injury:
   □ Head (incl. vision, hearing, speech) □ Systemic or non-physical □ Neck □ Chest □ Abdomen □ Back (upper / lower) □ Knee or lower leg (L or R)
   □ Ankle or Foot (L or R) □ Hip or upper leg (L or R) □ Shoulder / upper arm (L or R) □ Elbow / lower arm (L or R) □ Wrist / Hand (L or R)

3. Indicate Functional Capabilities (Complete in full)
   lifting □ Unable □ Limited: Specify: _____ carrying □ Unable □ Limited: Specify: _____
   push/pull □ Unable □ Limited: Specify: _____ sitting □ Unable □ Limited: Specify: _____
   standing □ Unable □ Limited: Specify: _____ walking □ Unable □ Limited: Specify: _____
   squatting □ Unable □ Limited: Specify: _____ reaching □ Unable □ Limited: Specify: _____
   bend/twist □ Unable □ Limited: Specify: _____ work above shoulder □ Unable □ Limited: Specify: _____
   repetitive work □ Unable □ Limited: Specify: _____
   Indicate any other limitations/restrictions (concentration, judgment, maintaining stamina, etc.)_____
   _____

4. Is the individual taking medication that may affect their ability to work? □Yes □No Specify limitations: _____
5. Duration of Restrictions: _____
6. Are the limitations considered permanent? □Yes □No In what period can recovery be anticipated? _____
7. Prognosis:_____
8. This employee will be reassessed on: _____
9. Comments:_____
   _____

Providers Name & Address (please print) _____

Signature: _____ Date:_____Phone Number:_____

RETURN TO WORK PLAN

This RETURN TO WORK PLAN has been developed by the employee, Supervisor, and Safety Officer exclusively for _____, and takes into account all of the functional capabilities identified by the health care provider on the Occupational Health Assessment Form (reverse side).

WORK WEEK (DATE)	DAYS/HOURS SCHEDULED EACH WEEK							COMMENTS
	MON	TUES	WED	THUR	FRI	SAT	SUN	

Additional Comments:_____
_____
_____

Expectations/Special Instructions

This plan will guide you in returning to your regular job activities by gradually increasing your duties as you recover from your injury.

- ☐ Check in regularly (**at the end of each day**) with your supervisor to let them know how you are progressing on the return to work plan.
- ☐ **Immediately contact your Supervisor if** you are not progressing as per your RTW plan or if you have any concerns or are asked to perform duties NOT included in this plan.

We agree to abide by this plan in an effort to succeed with a safe and fair return to work. Each party has an obligation to advise the others of any circumstances that might affect the plan. Changes to this agreement must meet the approval of all original parties.

_____ , _____, _____
EMPLOYEE SUPERVISOR DATE

OR

I have discussed the above plan with my supervisor and the Safety & Health Officer and am refusing to participate at this time.

_____, _____, _____
EMPLOYEE SUPERVISOR DATE