



# Fit for Work Statement

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occupationalhealth@slmhc.on.ca

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

A-G: To be completed by the Health Care provider
Assessment date: dd/mm/yy
Date illness/injury began: dd/mm/yy
Nature of illness:
Secondary to:
Under active/continuous care/ treatment from a physician: <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient compliant with treatment plan: <input type="checkbox"/> Yes <input type="checkbox"/> No

B: Current Physical Restrictions (only check those which apply) N/A <input type="checkbox"/>					
<b>To be completed by the Health Care provider</b>	<b>Walking</b> <input type="checkbox"/> 10-30 minutes <input type="checkbox"/> 1-10 minutes <input type="checkbox"/> no walking	<b>Standing</b> <input type="checkbox"/> 10-30 minutes <input type="checkbox"/> 1-10 minutes <input type="checkbox"/> no standing	<b>Sitting</b> <input type="checkbox"/> 10-30 minutes <input type="checkbox"/> 1-10 minutes <input type="checkbox"/> no sitting	<b>Stairs</b> <input type="checkbox"/> unable	
	<b>Lifting</b> <input type="checkbox"/> 5 - 10 kg <input type="checkbox"/> 1 - 5kg <input type="checkbox"/> < 1kg <input type="checkbox"/> no lifting	<b>Pushing/pulling</b> <i>Lt arm</i> <i>Rt arm</i> <input type="checkbox"/> 5-10 kg <input type="checkbox"/> <input type="checkbox"/> 1-5 kg <input type="checkbox"/> <input type="checkbox"/> < 1 kg <input type="checkbox"/> <input type="checkbox"/> no pushing/pulling <input type="checkbox"/>	<b>Gripping/pinching</b> <i>Lt hand</i> <i>Rt hand</i> <input type="checkbox"/> 1-5 kg <input type="checkbox"/> <input type="checkbox"/> up to 1kg <input type="checkbox"/> <input type="checkbox"/> no gripping/pinching <input type="checkbox"/>	<b>Visual</b> <input type="checkbox"/> depth <input type="checkbox"/> color <input type="checkbox"/> field <input type="checkbox"/> _____	
	<b>Vibration exposure</b> <input type="checkbox"/> whole body <input type="checkbox"/> hand/arm <input type="checkbox"/> other _____	<b>Environmental exposure</b> <input type="checkbox"/> heat/cold <input type="checkbox"/> noise <input type="checkbox"/> scents <input type="checkbox"/> other _____	<b>Side-effects from medication</b> _____ <input type="checkbox"/> Permanent <input type="checkbox"/> Short-term		
	<b>Other:</b> <input type="checkbox"/> Bending/Twisting of _____ <input type="checkbox"/> Repetitive movement of _____ <input type="checkbox"/> Chemical exposure of _____				
	Additional details of restrictions:				
	<b>Duration of Restrictions: (dd/mm/yy)</b>				

C. Current Cognitive Restrictions (only check those which apply) N/A <input type="checkbox"/>					
<b>To be completed by the Health Care provider</b>	<b>Attention/Concentration/ Decision making</b> <input type="checkbox"/> Limited <input type="checkbox"/> no attention/ concentration/decision	<b>Communication</b> <input type="checkbox"/> Speech <input type="checkbox"/> Writing	<b>Understanding/memory</b> <input type="checkbox"/> limited <input type="checkbox"/> no understanding/ memory	<b>Public Contact</b> <input type="checkbox"/> Limited <input type="checkbox"/> no public contact	
	<input type="checkbox"/> <b>Medication/s that have the potential of causing cognitive impairment at work</b> List all current medication and side effects causing impairment (i.e.: analgesic/sedatives, etc.) _____				
	Additional details of restrictions:				
<b>Duration of Restrictions: (dd/mm/yy)</b>					

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<b>D. Current Infectious Restrictions</b> (only check those which apply) <b>N/A</b> <input type="checkbox"/>			
<b>To be completed by the Health Care provider</b>	<input type="checkbox"/> Contact (Gastro, C-Diff, MRSA, VRE)	<input type="checkbox"/> Droplets (Cold, Influenza)	<input type="checkbox"/> Airborne (Active TB, chicken pox)
	Additional details of restrictions:		
	<b>Duration of Restrictions: (dd/mm/yy)</b>		

<b>E. Other restriction or comments</b> (only check those which apply) <b>N/A</b> <input type="checkbox"/>	
<b>To be completed by the Health Care provider</b>	<input type="checkbox"/> <b>Pain limiting return to work</b>
	Details:
	<input type="checkbox"/> <b>Other restrictions/limitations/comments</b>
	Details:
Additional details of restrictions:	
<b>Duration of Restrictions: (dd/mm/yy)</b>	

<b>F. Return to work/follow-up plan</b>	
<b>To be completed by the Health Care provider</b>	Reassessment required: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of next appointment: dd/mm/yy

<b>G. To be completed by the Health Care provider</b>	
By affixing my signature below, I certify that I am a qualified registered health care professional and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.	
<b>Physician/practitioner Name: (Please print)</b> _____	
<b>Telephone:</b> _____	
<b>Signature:</b> _____	

<b>H. To be completed by the Staff Member</b>	
I authorize the practitioner to complete and release all sections of this form, pertaining to my current or recent medical condition, to my employer's Staff Health/Occupational Health Specialist.	
Signature: _____	Date: _____

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