Niagara Emergency Medical Services

Functional Abilities Form

Dear Health Care Provider,

Niagara Emergency Medical Services is committed to supporting our employees overall health and wellbeing and during their recovery from illness or injury. We are respectful of the principles articulated in Canadian Medical Association policies on the physician's role in supporting ill or injured employees. We strive to enable employees to remain-at-work by accommodating their needs or to return-to-work as soon as it is medically appropriate.

We are committed to work collaboratively with you and the employee to develop a safe and suitable, personalized modified work plan based on their abilities and within their limitations provided by you. This program will be a living document and will be amended when medical is provided or during employee check in's if required.

In this regard we are requesting that you complete the attached functional abilities form and provide as much information as necessary to determine functional and cognitive limitations/restrictions. This information will enable us to arrange a reasonable accommodation (e.g., modified/alternate duties and/or work schedule, gradual return to work, adjustments to equipment), if applicable, and ensure a healthy, safe and supportive work environment.

Niagara EMS will reimburse the employee for professional fees associated with the completion of this form with a receipt.

Please do not include any diagnostic or treatment information (including medication).

Thank you for working with us to support our employee in their recovery.

Respectfully,

Niagara EMS Leadership Team

Niagara Emergency Medical Services

Functional Abilities Form

A. EMPLOYEE TO COMPLETE		
Employee Name:	Employee Number:	Phone:
Job Title:	Work Location:	Supervisor Name:

B. HEALTH CARE PROFESSIONAL TO COMPLETE – Please identify your patient's overall abilities and restrictions.

INSTRUCTIONS TO PHYSICIAN

FOR THE CURRENT ABSENCE: Niagara EMS has a comprehensive accommodation/modified work program that supports overall wellness and allows for a speedy and safe return to work. In order to support this program, we are requesting that this employee receive a medical assessment from a health care professional that will either assist the Service in providing appropriate workplace accommodations or confirm eligibility for sick leave entitlement.

RETURN TO WORK: If this form is being completed for return-to-work purposes, please indicate what restrictions (if any) require accommodations and the expected duration.

Please **ONLY** complete the relevant sections of the form (i.e., physical, psychological and/or environmental). For more information, please call 905-685-4225 ext. 3636.

Date of Assessment:	Illness/Injury Occurrence:	Illness/Injury (Circle One):	Nature of Illness/Injury (Not Diagnosis):
DD MM YYYY	DD MM YYYY	Work Related Not Work-Related Unknown Motor Vehicle Accident	

MEDICATIONS

☐ No Restrictions

Is the employee currently taking any medications that could impact upon his/her ability to work safely? ☐ Yes ☐ No

Please indicate any restrictions *specifically* related to medication: ____________________

Is the employee able to operate a motor vehicle? ☐ Yes ☐ No

PHYSICAL ASSESSMENT

Please **ONLY** complete the next section of this form specific to the current absence and **ONLY** if employee's current absence is physical in nature,

☐ No Restrictions

*Fully Capable	No change to regular functioning
*Occasional	Minor reduction to functionality; tasks requiring demand should be limited.
*Significant	Significant reduction to functionality for tasks requiring this demand, 1-3 hours max/shift.
*Total Restrictions	Restricted/incapable of performing tasks requiring this demand

Strength	Fully Capable*	Occasional*	Significant*	Total Restriction*	Physician's Comments
Lifting (waist to chest)	51.5kg	< 51.5kg	< 25kg		
Lifting (floor to waist)	55kg	< 55kg	< 25kg		
Carrying/transferring/repositioning	55kg	< 55kg	< 25kg		
Pushing					
Pulling					
Mobility					
Walking					
Sitting					
Standing					
Bend/twist at waist					
Bend/twist at knees					
Neck motion					
Crawling					
Balancing					
Kneeling					
Precision work/line manipulation/fine motor skills					
Forceful grip					
Ability to use hands/arms: Above shoulder activity					
Below shoulder activity					
In front/side body					
Repetitive Movement					
Repetitive hand/arm movement					
Typing					
Answering/taking telephone messages					
Handwriting/filing/paperwork					

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PSYCHOLOGICAL ASSESSMENT	Please **ONLY** complete the next section of this form specific to the current absence and **ONLY** if employee's current absence is psychological in nature	☐ **No Restrictions**
*Fully Capable	No change to regular functioning	
*Occasional	Minor reduction to functionality; tasks requiring demand should be limited	
*Significant	Significant reduction to functionality for tasks requiring this demand, 1-3 hours max/shift	
*Total Restrictions	Restricted/incapable of performing tasks requiring this demand	

Psychological Demands	Fully Capable*	Occasional*	Significant*	Total Restriction*	Physician's Comments
Self-supervision/motivation/independent work					
Supervision of others					
Work alone					
Work cooperatively with others in a team environment					
Exposure to emotional situations					
Exposure to confrontational situations					
Verbal communications					
Critical decision making					
Skills Demands					
Reading literacy					
Written literacy					
Numerical Skills					
Computer literacy					
Machine/equipment operation					
Driving ambulance *(Paramedic only)*					
Driving ambulance with warning systems (lights and sirens) *(Paramedic only)*					
Driving administrative vehicles					
Cognitive Demands					
Deadlines/time pressures					
Attention to detail					
Multi-task performance					
Memory					
Organizational and planning					
Responsibility and accountability					
Problem solving					
Sensory Demands					
Visual					
Auditory					
Touch					
Smell					
Environmental Sensitivities					
Temperature/Location/Ventilation					
Chemical exposure *(Paramedic only)*					

RETURN TO WORK	
The employee has restrictions until: ___________ DD / MM / YY	Next appointment date is: ___________ DD / MM / YY
The employee can return with no restrictions: ___________ DD / MM / YY	Comments:
Recommendation for modified work hours: ☐ Full-time ☐ Reduced ___________ # of hours	
If the employee is **unable** to return to work at this time, please indicate the reasons why and the duration.	
Other restrictions, comments or recommendations.	

Health Care Provider's Name (please print):	**Address:**	
Signature:	**Date:**	**Telephone:**

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EMPLOYEE TO COMPLETE – AUTHORIZATIONS FOR RELEASE OF INFORMATION	
I hereby authorize my treating Health Professional (name) ____ to release the information requested on this Functional Abilities Form. The information provided, with exception of the nature of the current illness/injury will be disclosed to my responsible manager/supervisor of the corporation and/or Human Resource Representatives as per the Work Accommodation Policy (C3.T05) to certify my entitlement to medical benefits, ensure my safety, assist in proper job placement and to accommodate a disability. A photocopy of this authorization will be considered as the original.	
Employee Signature:	**Date:**

If clarification regarding what is recorded on this Form is required and to avoid a delay or disruption in benefits or return to work, I authorize the Employee Health Services-Disability Management Coordinator to contact my health professional for such clarification. A photocopy of this authorization will be considered as the original. No new medical information is to be requested pursuant to this paragraph.	
Employee Signature:	**Date:**

Voluntary Consent - I hereby authorize my treating Health Professional (name) ____ to release any relevant medical information related to my current absence to the Employee Health Services-Disability Management Coordinator and I also authorize the Employee Health Services-Disability Management Coordinator to contact my above-noted Health Professional to discuss this medical information with the above-noted Health Professional. A photocopy of this authorization will be considered as the original.	
Employee Signature:	**Date:**

This consent may be signed by the Employee when they first provide their Functional Abilities Form. But it will only be used if the Employee Health Services-Disability Management Coordinator requires additional information not contained in the Functional Abilities Form. Please identify below if you wish the Employee Health Services-Disability Management Coordinator to notify you that it is requesting additional information (check one):

☐ It is not necessary to notify me

☐ Call me and leave a message at ________________________ if I am not available **(only one phone call will be made)**

☐ Call me at ________________________, but do not leave a message if I am not available **(no further calls will be made)**

PLEASE RETURN THE COMPLETED FORM to EMPLOYEE HEALTH SERVICES (Do not send directly to your OPS)

Via Confidential Fax At **(905)-685-5355 OR** Via Email to ehs@niagararegion.ca

- This form is also available on-line at **https://remote.niagararegion.ca**
- The submission deadline for all employees is within 24 hours after seeing a Health Care Provider and within 10 calendar days following the first sick day.
- Cost of this form is the responsibility of the patient. Reimbursement will be provided for the reasonable and customary cost to complete this form by submitting the original receipt to Employee Health Services via email or fax as stated above within fifteen (15) calendar days from the date.