Certificate of Illness / Abilities Form

The Five Hills Health Region has an active Abilities Management program which strives to promote the well being of employees and make every effort to support employees in safely staying in or returning to the workplace.

To allow for continuity and adequate information to approve sick time usage or guide a safe return-to-work, this form is the preferred document with all Five Hills Health Region Employees. Thank you for your anticipated assistance.

Employee Name: _____ Date of Birth: _____

☐ This patient is medically able to work with limitations or restrictions as of: _____

In my opinion, these restrictions or limitations are:

☐ Temporary: ☐ _____ days ☐ less than 2 weeks ☐ 2 to 4 weeks ☐ 4 to 6 weeks
☐ 6 weeks to 3 months ☐ more than 3 months

☐ Permanent

☐ This patient is <u>not</u> medically fit for accommodated duties. Date of reassessment: _____

Please check only those items that apply in Section A, and provide details in Section B. If unable to test, please estimate.

Section A	Restrictions/Limitations		Restrictions/Limitations
Physical		*Mental/Cognitive*	
Sitting	☐ ____ consecutive minutes	Thinking/Reasoning	☐
Standing	☐ ____ consecutive minutes	Concentration and Memory	☐
Walking	☐ ____ minutes/distance	Interpersonal Contact	☐
Pushing/Pulling	☐ ____ lbs	Critical Decision-making	☐
Lifting	☐ ____ lbs Floor-Waist ☐ ____ lbs Waist-Shoulder ☐ ____ lbs Shoulder-Overhead	Currently prescribed medications that may impair ability to function at work, explain:	
Carrying	☐ ____ lbs	Alertness/Fatigue	☐
Crouching/Crawling/Kneeling	☐	*Other*	
Climbing Stairs	☐ ____ # steps	Exposure to heat/cold	☐
Climbing ladders	☐	Exposure to dust/fumes/odors	☐
Bending/Twisting/Turning	☐	Operating vehicle/equipment	☐
Sustained postures	☐	Food handling	☐
Repetitive Activity	☐	Balance	☐
Gripping	☐	Working at heights	☐
Fine dexterity	☐	Vision/Hearing/Speech	☐
Reaching	☐ Above Shoulder height ☐ Below Shoulder height	Other:	☐
Section B Comments/Details: _____			

Restrictions to stamina, working hours, or shifts: ☐ No Restrictions ☐ 2 hours ☐ 4 hours ☐ 6 hours ☐ 8 hours
☐ 10 hours ☐ 12 hours ☐ Graduated hours over ____ weeks

Restrictions to # shifts/week: ☐ No Restrictions ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Date of Next Reassessment/Follow-up: _____

_____ _____ _____
Health Care Providers Name Signature Date