Annapolis Valley Regional School Board
Working Together for Students

305.15 Appendix F

Request for Functional Information of Presenting Illness/Injury

Director of Human Resources
Annapolis Valley Regional School Board
PO Box 340, 121 Orchard Street
Berwick, Nova Scotia B0P 1E0
Phone: 538-4600 Fax: 538-4635

The Annapolis Valley Regional School Board has developed a return to work policy to assist employees in their rehabilitation and return to full health and employment. Part of the process is to get information about your current abilities from your physician as it relates to your illness/injury. To do this we ask that you have your physician complete this form.

Section 1 (To be completed by EMPLOYEE)	
Employee's Name:	**Employee Number:**
Address:	**Telephone (Home):**
School/Site:	**Telephone (Work):**
Immediate Supervisor:	**Telephone (Work):**
EMPLOYEE: I authorize my Healthcare provider to disclose information related to my current illness or injury to my Employer for the purpose of developing a safe return to work plan. The Employer will keep this information confidential. It is understood that this information shall only be of the same nature and extent as disclosed in Section 2 of this Form and the attached Physical Capability Assessment Form, and does not authorize the release of information which is different in nature or greater in extent. I understand that I will receive a copy of any medical information received by the Board from my physician and will be made aware of any further requests for medical information from the Board.	
Employee's Signature:	**Date:**

Section 2 (To be completed by Physician or Authorized Health Professional)

Does Employee have any impairment that currently impairs the employee from returning to unrestricted duties?

_____ NO Employee can return to unrestricted work activities.

_____ YES If yes, please answer the following questions.

If the employee currently has a physical impairment, please complete the Physical Capability Assessment (on reverse side). If the impairment is non physical, please describe the current limitations the employer should bear in mind. PLEASE DO NOT INCLUDE A DIAGNOSIS.

_____
_____
_____
_____

Duration of impairment:	**Expected date of return to regular duties of work?**
_____ 2-4 weeks _____ 4-6 weeks _____ 6-8 weeks	
_____ 3 months or more	

(Optional) Are there workplace barriers that could be modified or a course of action that the Employer could take to assist in recovery and rehabilitation?

_____
_____

Health Care Provider: The information provided in this document is true and based on my examination of the patient.	
Signature:	
Name (Print):	
Mailing Address:	
Telephone Number:	**Fax Number:**

FOR EMPLOYEE ONLY: Any fee applicable to completing this form should be billed directly to the Annapolis Valley Regional School Board.

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Physical Capability Assessment of presenting illness/injury

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Phone: 538-4600 Fax: 538-4635

Employee Name: _____

LIFTING	No Restriction	Occasional	Restricted
Sedentary			
Light			
Medium			
Heavy			

STANDING	No Restriction	Occasional	Restricted
1 hr – 2 hr			
2 hr – 4 hr			
4 hr – 6 hr			
6 hr – 8 hr			

CARRYING	No Restriction	Occasional	Restricted
Sedentary			
Light			
Medium			
Heavy			

WALKING	No Restriction	Occasional	Restricted
1 hr – 2 hr			
2 hr - 4 hr			
4 hr – 6 hr			
6 hr – 8 hr			

BENDING	No Restriction	Occasional	Restricted
To a desk			
To the floor			

L ARM USE	No Restriction	Occasional	Restricted
Above Shoulder			
Below Shoulder			

CLIMBING	No Restriction	Occasional	Restricted
Stairs			
Ladders			

R ARM USE	No Restriction	Occasional	Restricted
Above Shoulder			
Below Shoulder			

SITTING	No Restriction	Occasional	Restricted
1 hr – 2 hr			
2 hr – 4 hr			
6 hr – 8 hr			

L HAND USE	No Restriction	Occasional	Restricted
General Tasks			
Fine Control			
Gripping			

SHOULDER MOVEMENT	No Restriction	Occasional	Restricted
1 hr – 2 hr			
2 hr – 4 hr			
6 hr – 8 hr			

R HAND USE	No Restriction	Occasional	Restricted
General Tasks			
Fine Control			
Gripping			

VOICE	___ No Difficulty	___ Occasional Difficulty	___ Constant Difficulty

HEARING	___ No Difficulty	____ Occasional Difficulty	____Constant Difficulty

Health Care Provider: The information provided in this document is true and based on my examination of the patient.	
Signature:	**Date:**
Professional Designation:	
Mailing Address:	
Telephone Number:	**Fax Number:**