Office of Human Resources
(807) 343-8010 ext 8671
e: trmoore@lakeheadu.ca

Dear Health Care Professional,

You are being asked to complete the following Medical Documentation Form by an employee who is requesting accommodations due to a medical limitation/restriction or to document an employee's inability to work due to limitations. We seek the following information:

1. Confirmation and verification that the employee has a permanent or temporary disability/medical condition
2. Confirmation of functional limitation the employee experiences directly related to their disability/medical condition

Please note interim accommodations can be provided for employees who are in the process of being assessed for a mental health disability.

Lakehead University is guided by the Ontario Human Rights Code and the Lakehead University Accommodation for Employees with Disabilities Procedure (temporary and permanent, work/non-work related). We rely on your assessment and detailed knowledge of this employee and their disability/medical condition to provide us with a description of the current functional limitation and restrictions that may impact their ability to complete their assigned duties.

The information you provide will be used by the Office of Human Resources to design an individualized accommodation plan. This plan helps to ensure the employee has an equitable opportunity to fulfill the essential occupational requirements at Lakehead University.

Disclosing a diagnosis is not required to access accommodations. Any information provided on this form will be kept strictly confidential and will not be shared with anyone outside of the Office of Human Resources without the employee's written consent.

A Job Demands Report has been completed and included in this package to assist you.

If you have any questions or concerns, please contact our office:
Thunder Bay and Orillia Campus
Phone: (807) 343-8010 ext. 8671

Email: trmoore@lakeheadu.ca

Functional Accommodation/Abilities Form For a Timely Return To Work

SECTION A: Completed by the Employee

Employee Name	Date of Assessment:
Job Title	DOB

Authorization: I authorize my health professional involved with my treatment to provide my employer with this form when completed, containing any medical limitations/restrictions related to my ability to return to work and perform my assigned duties.

Employee Signature: Date:

SECTION B: (to be completed by a licensed medical practitioner)

Complete all relevant sections. Missing information will require the employer to follow-up. Please reference any job description, physical demands analysis or job summary that have been provided in determining any restrictions.

□ Normal Functional Abilities - fit for regular duties and hours. **Skip to Section E**

□ Reduced Functional Abilities - fit for work with the limitations/restrictions. **Complete all Sections**

□ Unfit to Work. **Complete all Sections**

Is the employee under your active care?	□ Yes	□ No, please indicate other treatment providers:
Date of Next Medical Review	□ Yes	□ No, please explain:
Is there a treatment plan in place?	□ Yes	□ No, please explain:
Is the employee compliant with the Treatment?	□ Yes	□ No, please explain:
Was a formal assessment, testing or measurement completed to determine functional abilities?	□ Yes	□ No, please explain:
Estimated Return to Work Date (if absent):		

SECTION C: (to be completed by a licensed medical practitioner)

PHYSICAL LIMITATIONS □ This employee does not have Physical Limitations			
Lifting floor to waist: □ Full abilities □ 5-10 kg □ Up to 5 kg □ None	**Lifting waist to shoulder:** □ Full abilities □ 5-10 kg □ Up to 5 kg □ None	**Lifting at or above shoulder:** □ Full abilities □ 5-10 kg □ Up to 5 kg □ None	**Sitting/Standing/Walking:** □ Full abilities □ 60 mins □ 15-30 mins □ None
Hand Function Dominance: □ Left or □ Right dominant □ Full abilities □ Avoid gripping/pinching □ None in dominant hand	**Pushing/Pulling:** □ Full abilities □ Occasional □ None	**Reaching:** □ Full abilities □ No over the shoulder □ No overhead	**Bending/Crouching/ Kneeling/Climbing:** □ Full abilities □ Occasional □ None

SECTION D: (to be completed by a licensed medical practitioner)

PSYCHOLOGICAL/EMOTIONAL LIMITATIONS □ This employee does not have Psychological/Emotional Limitations			
Supervision Required: □ Constant □ Frequent □ Limited	**Supervision of Others:** □ Unable to supervise others or take any responsibility for their safety □ Can provide limited direction to others and take some responsibility for their safety □ Can provide direction to others and take responsibility for their safety with assistance or monitoring	**Tolerance to Deadlines:** □ Cannot deal with deadlines □ Able to meet recurring deadlines □ Able to meet deadlines, with time management assistance	**Attention to Detail:** □ Severely limited □ Limited □ Requires occasional breaks
Performance of Multiple Tasks: □ Can deal with one task at a time □ Can handle more than one, with cues □ Can handle more than one, with time management assistance	**Concentration and Tolerance for External Stimulus:** □ Needs non distracting work environment □ Can cope with small degree of distraction □ Can cope with distracting stimuli a portion of the day	**Ability to work with others:** □ Has difficulty working effectively unless alone □ Tolerates others in vicinity, but requires independent tasks □ Can work with others cooperatively when required.	**Ability to cope with confrontational situations:** □ Unable to cope with confrontational situations □ Can cope when backup is available □ Moderate ability to cope with confrontational situation
Decision Making/ Judgement: □ Errors in judgement or indecision likely □ Has difficulty making decisions and/or may require support in decision-making tasks. □ Hesitates to make decisions or doesn't trust their own judgement	**Learning and Memory:** □ Severely limited □ Limited but ability to perform tasks with guidance □ Moderate ability; easily recalls when prompted.	**Communication:** □ Unable to communicate effectively □ Able to communicate with familiar audiences in a limited capacity □ Able to communicate with familiar and unfamiliar audiences when required	**Adaptation:** □ Unable to cope with change □ Able to cope with minor changes when provided notice in advance □ Able to cope with moderate change

Other Limitations/Restrictions: (provide details):
Are these limitations/restrictions permanent or temporary? If temporary, please indicate the duration expected:
☐ Permanent ☐ Temporary Duration:
Other details to be considered in the accommodations plan:

SECTION E:
By affixing my signature below, I certify that I am a licensed medical practitioner. I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

Name (please print):	Health Profession (please print):
Address:	Phone: Fax:
Signature:	Date:

Once completed: please email to trmoore@lakeheadu.ca.