Functional Abilities Form

for Planning Early and Safe Return to Work

Health Professionals, please use this form ONLY when requested by an employer or worker.

The purpose of this form is to identify your patient's overall functional abilities and work restrictions that will assist his/her return to suitable work.

Please promptly complete and return pages 2 and 3 of this form to the worker or employer to assist the workplace parties in planning an early and safe return to work.

PLEASE ENSURE YOUR BILLING INFORMATION IS NOT GIVEN TO THE WORKER OR EMPLOYER.

Authority to Release Information

Section 37(3) of the *Workplace Safety and Insurance Act, 1997* provides the legal authority for health professionals to give the Workplace Safety and Insurance Board (WSIB), the injured worker and the employer such information as may be prescribed concerning the worker's functional abilities.

When completing this report, please **print** in **black ink**.

Worker and/or employer should complete Sections A and B of this report. If your patient needs assistance, please help. Please submit this report even if Section A is not fully completed.

Information about your responsibilities can be found on **Page 4**.

The WSIB will pay health professionals for completing this form.

Mail to:
Workplace Safety and Insurance Board
200 Front Street West
Toronto, ON M5V 3J1

OR

Fax to:
416-344-4684
or 1-888-313-7373

wsib
ONTARIO

A guide to completing this form is available at www.wsib.on.ca

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Please PRINT in black ink

FAF

Functional Abilities Form
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Claim No.

A. Section A to be completed by the employer and/or worker.

Worker's Last Name	First Name		Telephone
Address (no., street, apt.)	**City/Town**	**Province**	**Postal Code**

Employer's Name
Algonquin & Lakeshore CDSB

Full Address (No., Street, Apt.)
151 Dairy Ave

City/Town: **Napanee** | Prov.: **ON** | Postal Code: **K7R 4B2**

Date of Birth (dd/mm/yyyy)

Date of Accident/ Awareness of Illness (dd/mm/yyyy)

Employer Telephone: **613 354-6255**

Employer Fax No.: **613 354-4772**

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1. Type of job at time of accident (where available, please attach description of job activities) | Area(s) of injury(ies)/illness(es)

2. Have the worker and the employer discussed Return To Work ☐ yes ☐ no | If no, will be discussed on dd mm yyyy

3. Employer contact name | Position

fold

B. Worker's Signature

By signing below, I am authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board (WSIB) with information about my functional abilities on the WSIB's "Functional Abilities for Planning Early and Safe Return to Work" form.

Signature | Date dd mm yyyy

C. Health Professional's Billing Information

For billing purposes fax or mail pages 2 and 3 to the WSIB.

Health Professional's Designation

☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class) ☐ Other

PROVIDER BILLING INFORMATION IN THE BOLDED AREA OF SECTION C SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER.

Are you registered with the WSIB? ☐ yes Please enter the **WSIB Provider ID.** in the box provided ▶ ☐ no Please call **1 - 800-569-7919** to register

WSIB Provider ID.

Your Invoice Number

Service Code **FAF**

▼ Complete these fields if **HST** is applicable to this form ▼

HST Registration Number	Service Code	HST Amount Billed
	ONHST	**$** .

Health Professional's Name (please print)

Address (No. Street, Apt.)

City/Town	Province	Postal Code	Fax

I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation to the WSIB.

Health Professional's Signature	Telephone	Date dd mm yyyy

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Worker's Last Name	First Name	Claim No.

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment dd mm yyyy

2. Please check one:

- ☐ Patient is capable of returning to work with **no restrictions.**
- ☐ Patient is capable of returning to work **with restrictions.** Complete sections **E and F.**
- ☐ Patient is physically unable to return to work at this time. Complete section **F.**

E. Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Lifting from waist to shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

Ladder climbing:
- ☐ Full abilities
- ☐ 1 - 3 steps
- ☐ 4 - 6 steps
- ☐ Other (please specify)

Travel to work:

Ability to use public transit	Ability to drive a car
☐ yes	☐ yes
☐ no	☐ no

2. Please indicate **Restrictions** that apply. Include additional details in section 3

- ☐ Bending/twisting repetitive movement of (please specify)
- ☐ Work at or above shoulder activity:
- ☐ Chemical exposure to:
- ☐ Environmental exposure to: (e.g. heat, cold, noise or scents)
- ☐ Limited use of hand(s):

Left		Right
☐	Gripping	☐
☐	Pinching	☐
☐	Other (please specify)	☐

- ☐ Limited pushing/pulling with:
  - ☐ Left arm
  - ☐ Right arm
  - ☐ Other (please specify)
- ☐ Operating motorized equipment: (e.g. forklift)
- ☐ Potential side effects from medications (please specify) Do not include names of medications.
- ☐ Exposure to vibration:
  - ☐ Whole body
  - ☐ Hand/Arm

3. Additional Comments on **Abilities and/or Restrictions.**

4. From the date of this assessment, the above will apply for approximately:
☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Have you discussed return to work with your patient? ☐ yes ☐ no

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours

Start Date dd mm yyyy

F. Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions.** dd mm yyyy

I have provided this completed Functional Abilities Form to: ☐ **Worker** **and/or** ☐ **Employer**

Important Information

To receive benefits, the worker must apply for benefits within six months of the date of a work-related injury or illness. When filing a claim for benefits, the worker must also consent to the disclosure of functional abilities information provided by a health professional to his or her employer for the purpose of facilitating an early and safe return to work. Failure to file a claim or provide consent for the release of the functional abilities information can result in no benefits.

If you have questions about the completion of this form please call 1-800-387-0750.

Worker's Responsibilities

- This form is to be completed by a treating health professional, who will discuss the information with you.
- Once completed, contact your employer **immediately** to review the information on the completed form. Together, you and your employer will begin to plan an early and safe return to work.

Employer's Responsibilities

- This form provides general information about this worker's functional abilities and restrictions to help you plan an early and safe return to work.
- When you provide this form to the treating health professional, ensure that you have the worker's signed consent (Section B) for the release of functional abilities information.
- Where available, also attach a description of the worker's job activities to assist the health professional in completing the form.
- The prescribed form that is available from the WSIB is a generic form developed to assist with general functional abilities information.
- The WSIB will pay the health professional to complete the prescribed WSIB form only. A charge will appear on your Accident Cost statement or Schedule 2 Invoice which reflects the cost of payment for each form completed.
- If you have a form that is specific to your workplace and have the cooperation of the worker in providing consent for the release of information on your form, you may use your own form. If you create your own form, you must reimburse the health professional directly.
- Do not send a copy of the completed Functional Abilities Form for Planning Early and Safe Return to Work to the WSIB. The health professional is responsible for submission of the form.

Health Professional's Responsibilities

- The employer and worker will use this information to plan the worker's early and safe return to work.
- Their return to work plans will reflect the functional abilities and restrictions you have noted and presume that no clinical contraindications exist for other work activities, therefore it is crucial that all sections be completed in full.
- The completion of this form is based on your examination of the worker and does not require a specialized functional abilities evaluation.
- Diagnostic or confidential information **must not** be included.
- Please add specific information on the duration of temporary restrictions or maximum times or weights to be considered, in section **E3** under **abilities and/or restrictions**. If necessary, attach an additional page to this completed form to describe abilities and restrictions.
- **Completion of this form does not replace clinical reporting requirements to the WSIB.**
- **Once you have received this form, promptly complete it and give it to the worker and/or employer.**
- **For billing purposes fax or mail pages 2 and 3 to the WSIB. When faxing, do not mail a copy.**

The WSIB will pay the health professional for the completed form when pages 2 and 3 are received.

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