COMMUNITY LIVING-CENTRAL HURON
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519-524-7362 fax 519-524-1511
Goderich, Ontario N7A 4C7

RTW-06

EMPLOYEE RETURN TO WORK FORM

EMPLOYEE: _____ **POSITION**: _____

Nature of Injury/Illness/Condition: _____

The following information should be completed by the Health Professional:

Date of examination on which the report is based: _____

Area of injury: _____

Rehabilitation/Treatment required: ☐ Yes ☐ No

Is the worker capable of returning to work immediately without restrictions? ☐ Yes ☐ No If No, please complete the next section.

Please complete where capabilities are known or limitations recommended:

☐ **Walking**: short distance only ☐ ; other (e.g. uneven ground) ☐ _____

☐ **Standing**: less than 15 minutes ☐ ; less than 30 minutes ☐ ; other ☐ _____

☐ **Sitting**: less than 30 minutes ☐ ; less than 1 hour ☐ ; other ☐ _____

☐ **Lifting floor to waist:** less than 10 kg ☐ ; less than 25 kg ☐ ; other ☐ _____

☐ **Lifting waist to shoulder:** less than 10 kg ☐ ; less than 25 kg ☐ ; other ☐ _____

☐ **Stair climbing**: none ☐ ; 2-3 steps only ☐ ; 4-6 steps only ☐ ; _____

☐ **Ladder climbing**: none ☐ ; 2-3 steps only ☐ ; 4-6 steps only ☐ ; _____

☐ **Limited ability to use hand to**: hold objects ☐ ; grip ☐ ; type ☐ ; write ☐ ; _____

☐ **Pushing and pulling:** (duration, distance and weight) _____

☐ **Bending or twisting of** _____

☐ **Repetitive movement of** _____

☐ **Operating motorized equipment**: _____

☐ **Restrictions related to medications**: _____

☐ **Above - shoulder activity**: _____

☐ **Below - shoulder activity**: _____

Limit physical exertion to: **mild** ☐ ; **moderate** ☐ ; _____

Estimated Duration of Limitations: _____

Other:

☐ Restrictions related to medications (specify): _____

☐ Medically able to drive: ☐ Yes ☐ No

☐ **Shift Work**: _____

☐ **Are above restrictions**: Permanent ☐ ; Temporary ☐ ;

☐ **Estimated Duration of Restrictions (specify)**: _____

_____

☐ **Able to Return to Full-Time Hours**: Yes ☐ ; No ☐ If Yes, when: _____

☐ **Able to Return to Modified or Graduated Hours (Specify)**: _____

_____

☐ **Able to Return to Modified Duties**: Yes ☐ ; No ☐

Please list specific restrictions/capabilities that you feel are necessary for the health of this employee in planning for early and safe return to work (ie. modified duties, modified schedule, assistive devices, etc.)

_____

_____

_____

_____

_____

_____

_____

Expected Date of Recovery: _____

Treating Health Care Professional:

Name: _____ (Please print or use stamp)

Address: _____

_____

Phone: _____

Fax: _____

Signature: _____

Date: _____