Dear Treating Professional:

To accommodate our employees, Red Deer College has a Stay at Work/ Return to Work (RTW) program. In my role as Occupational Health Consultant, I strive to assist employees to continue or return to work, as soon as they are reasonably and safely able, without aggravating their injury or illness. I work with you to ensure the employee's medical limitations and recommendations are implemented with the goal of helping the employee recover and return to their regular duties. This is achieved by reviewing and modifying our injured/ill employee's current position to accommodate the medical limitations of the employee by altering specific tasks, reducing work hours or modifying workstations and equipment.

Please provide advice about medical restrictions by completing the attached Attending Physician's Assessment and Recommendations and/or the Functional Abilities Form for Timely Return to Work to assist us to develop a modified work plan.

Thank you for working with us to help our employees achieve the shared goal of a safe and timely return to work.

Sincerely,

Charmaine Grant RN, COHN
Occupational Health Nurse/Occupational Health Consultant | Health, Safety & Wellness Centre
Red Deer College |100 College Blvd. | Box 5005 | Red Deer | Alberta | T4N 5H5
work 403.342.3265 | fax 403.342-3303

Charmaine.Grant@rdc.ab.ca or Health.Safety@rdc.ab.ca
www.rdc.ab.ca | **when you get here you understand**

FUNCTIONAL ABILITIES FORM FOR TIMELY RETURN TO WORK

Employee Name: _____ Phone #: _____
Job Title: _____ Direct Supervisor/Manager:
_____

Authorization for Release of Information:

I authorize the physician/mental health professional to give documentation for my current medical condition to RDC Health, Safety and Wellness strictly for the purposes of validating my claim for disability and managing my absence and/or return to work. I consent to allow RDC Health, Safety and Wellness to provide information related to my fitness to work and any accommodation needs to my manager/supervisor/Human Resources and Union Representative (if applicable). A photocopy of this authorization is as valid as the original.

Employee Signature:_____ Date:_____
Nature of Illness/Injury: _____

Please complete only the limitations that are recommended (where applicable)

A. Walking/Standing/Sitting					
	Unable	**< 15 minutes**	**15-30 minutes**	**30-60 minutes**	**60 minutes**
Walking					
Sitting					
Standing					
Squatting/Kneeling					
Crouching					
B. Lifting/Pushing/Pulling					
	Unable	**Minimal (<10%)**	**Occasional (to 34%)**	**Frequent (35-66%**	
Lifting Floor to Waist					
Sedentary/Light (<7kg/15 lbs)					
Medium (<14 kg/30 lbs)					
Heavy (<25kg/55 lbs)					
Lifting Waist to Shoulder					
Sedentary/Light (<7kg/15 lbs)					
Medium (<14 kg/30 lbs)					
Heavy (<25kg/55 lbs)					
Lifting Above the Shoulder					
Sedentary/Light (<7kg/15 lbs)					
Medium (<14 kg/30 lbs)					
Heavy (<25kg/55 lbs)					
Pushing/Pulling					
Sedentary/Light (<7kg/15 lbs)					
Medium (<14 kg/30 lbs)					
Heavy (<25kg/55 lbs)					

Employee Name: _____

C. Other Physical Limitations			
	Minimal (<10%)	Occasional (to 34%)	Frequent (35-66%
Gripping			
Keyboarding			
Carrying			
Reaching overhead			
Bending/Twisting (cervical/lumbar)			
Climbing stairs/ladders			

D. Other limitations
Modified hours of work (please specify):

E. Cognitive Limitations						
	Yes	Adequately	Poor	No	No limitation	Comments
Coherent						
Problems maintaining focus/Attention/Concentration on the job						
Decision Making						
Judgement						
Emotional Control						
Ability to follow direction						
Problems relating to other people						
Difficulties performing simple and repetitive tasks						
Limited ability to perform complex and varied tasks						
Reduced energy and pace required for the job						
Problem responding appropriately to supervision and management						

Can this person work: Independently? Yes No	With Supervision? Yes No	With Assistance? Yes No	
Is complete recovery expected: Yes/No/Unknown			
Estimated duration of reduced capacity:			
Return/Follow-up appointment date:			
Additional Comments:			
Date of Next Assessment:		Date RTW Modified Duties:	
Estimated Duration of Limitations:		Date RTW regular Duties:	

By completing this Functional Abilities Form, the information contained herein will become part of the employee's medical file.
Modified work is available. *Please have the employee return this completed form to Health, Safety and Wellness.*

Health Professional Name:_____ Health Profession:_____

Date of Next Appointment:_____
Telephone:_____

Address:_____
City/Town:_____

Signature:_____ Date:_____

If you have any questions about the collection and use of this personal information, please contact the Health, Safety and Wellness Centre at 403.342.3427. Return form by confidential fax, email, or mail to Health, Safety and Wellness. Confidential Fax #: 403.342.3303 Email: Health.Safety@rdc.ab.ca Address: Red Deer College, 100 College Blvd, Box 5005, Red Deer, AB, T4N 5H5