

Please PRINT in black ink

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

Full Address (No., Street, Apt.)

City/Town

Prov.

Postal Code

Date of Birth
(dd/mm/yyyy)

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

Employer
Telephone

Employer
Fax No.

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

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 BOLDDED AREA OF SECTION C SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER.

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

WSIB Provider ID.

Your Invoice Number

Health Professional's Name (please print)

Service Code

FAF

Address (No. Street, Apt.)

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

HST Registration Number

Service Code

HST Amount Billed

ONHST

\$

.

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

Please PRINT in black ink

Worker's Last Name	First Name	Claim No.
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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.
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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: <table style="width:100%;"> <tr> <td style="width:50%;">Ability to use public transit</td> <td style="width:50%;">Ability to drive a car</td> </tr> <tr> <td>☐ yes ☐ no</td> <td>☐ yes ☐ no</td> </tr> </table>	Ability to use public transit	Ability to drive a car	☐ yes ☐ no	☐ yes ☐ no				
Ability to use public transit	Ability to drive a car										
☐ yes ☐ no	☐ yes ☐ 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): <table style="width:100%;"> <tr> <td style="width:50%;">Left</td> <td style="width:50%;">Right</td> </tr> <tr> <td>☐</td> <td>☐</td> </tr> <tr> <td>☐</td> <td>☐</td> </tr> <tr> <td>☐</td> <td>☐</td> </tr> </table>		Left	Right	☐	☐	☐	☐	☐	☐	☐ Gripping ☐ Pinching ☐ Other (please specify)	
Left	Right										
☐	☐										
☐	☐										
☐	☐										
☐ 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.**

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
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I have provided this completed Functional Abilities Form to:

☐ **Worker**

and/or

☐ **Employer**