

## OCCUPATIONAL HEALTH ASSESSMENT FORM

## TO ALL EMPLOYEES:

Please return this completed form to your supervisor within 24 hours of being away from work due to accident or illness, and/or prior to the start of your next scheduled shift.

	AUTHORIZATION TO RELEASE INFORMATION
dod	nderstand that modified or alternate duties are available at Pembina Trails School Division to assist with my return to work. I authorize my ctor, to release information to Pembina Trails School Division concerning my functional capabilities and/or limitations and restrictions. I give mission for Human Resources to contact my Health Care Provider to discuss or clarify information obtained on this form and /or return to rk.
	Employee Name (please print) Employee Signature Date (mm/dd/yyyy)
Ple	TENDING PHYSICIAN (Please complete in full, including restrictions & capabilities section): ease ensure the above authorization is signed before completing the following information. This will assist Pembina Trails School Division in eviding the earliest, safest, meaningful, and productive return to work possible for this employee.
1.	
	a) is able to return to regular work duties?   Yes   No  Reduced Hours Please Specify:
	b) is able to work normal scheduled nodis?   Tes   No Reduced nodis Please Specily
2.	Indicate the location of the injury:  □ Head (incl. vision, hearing, speech) □ Systemic or non-physical □ Neck □ Chest □ Abdomen □ Back (upper / lower) □ Knee or lower leg (L or R) □ Ankle or Foot (L or R) □ Hip or upper leg (L or R) □ Shoulder / upper arm (L or R) □ Elbow / lower arm (L or R) □ Wrist / Hand (L or R)
3.	Indicate Functional Capabilities (Complete in full)    lifting
4.	Is the individual taking medication that may affect their ability to work?
5.	Duration of Restrictions:
6.	Are the limitations considered permanent?   —Yes  —No   In what period can recovery be anticipated?
7.	Prognosis:
8.	This employee will be reassessed on:
9.	Comments:
Pro	viders Name & Address (please print)

Signature:

Date:

Phone Number:



## **RETURN TO WORK PLAN**

on the Occupation		, and	takes into	account a	all of the			nd Safety Officer exclusively for ties identified by the health care provider
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WORK WEE (DATE)		AYS/HO				CH WE	EK SUN	COMMENTS
(DATE)	MON	TOLO	WLD	THOIL	I IXI	JAI	JON	
Additional Commer	nts:							
Expectations/	•							
								duties as you recover from your injury.  but are progressing on the return to work plan.
☐ Immediately c	ontact your	Superviso	<b>r if</b> you a	re not progr	essing as	per your l	RTW plan	or if you have any concerns or are asked to
perform duties	NOT include	d in this pla	n.					
•	,							party has an obligation to advise the others of val of all original parties.
arry or our rotation	that might ar	root trio piai	i. Onange	o to tino ag	roomone	muot moot	тто аррго	val of all original partico.
EMPLOYEE			,	S	SUPERVISOR	?		DATE
I have discussed th	e above plar	n with my su	pervisor a	OR and the Safe	ety & Hea	alth Officer	and am re	efusing to participate at this time.
	·	•			-			
EMPLOYEE				S	SUPERVISOR	?	,	DATE