



FUNCTIONAL ABILITIES FORM

401 Strickland Street, Whitehorse, Yukon, Y1A 5N8, **Telephone:** (867) 667-5645, **Toll free:** 1-800-661-0443, **Fax:** (867) 667-8740, **Website:** www.wcb.yk.ca

WORKER'S INFORMATION		
Worker's Surname		
First Name		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone #	Date of Birth (d/m/y)
Part of Body Injured		

HEALTH CARE PROVIDER'S INFORMATION	
Health Care Provider's Name	
Health Care Provider's Address	
Health Care Provider's Telephone #	
Date of Visit (d/m/y)	Time of Visit
or Health Care Provider's Stamp	

PART A
<input type="checkbox"/> Patient has no functional limitations

PART B
<input type="checkbox"/> Patient has functional limitations and can return to work providing the following limitations can be appropriately accommodated: <ul style="list-style-type: none"> <input type="checkbox"/> No lifting <input type="checkbox"/> No overhead lifting <input type="checkbox"/> Lifting as tolerated <input type="checkbox"/> Walking* <input type="checkbox"/> Other* _____ <input type="checkbox"/> Use of upper extremity* <input type="checkbox"/> Bending, twisting or kneeling <input type="checkbox"/> Climbing stairs/ladders <input type="checkbox"/> Standing* <input type="checkbox"/> Sitting* <input type="checkbox"/> Limitations due to medications* <input type="checkbox"/> Limitations due to environmental conditions <input type="checkbox"/> Reduced hours*
*Please provide further details on these limitations _____

Estimated duration of functional limitations (in days) _____

<input type="checkbox"/> I have reviewed details of this report with patient	Date of next visit (d/m/y) _____
I certify that this is a complete and accurate report. The fees charged are in accordance with the medical fee schedule and I have received no prior payment.	
Health Care Provider's Signature _____	Date (d/m/y) _____