Yukon Workers' Compensation Health and Safety Board

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

☐ Male ☐ 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 Injury *(d/m/y)*

Time of Visit

or Health Care Provider's Stamp

PART A

☐ Patient has no functional limitations

PART B

☐ Patient has functional limitations and can return to work providing the following limitations can be appropriately accommodated:

- ☐ No lifting
- ☐ No overhead lifting
- ☐ Lifting as tolerated
- ☐ Walking*
- ☐ Other* _____
- ☐ Use of upper extremity*
- ☐ Bending, twisting or kneeling
- ☐ Climbing stairs/ladders
- ☐ Standing*
- ☐ Sitting*
- ☐ Limitations due to medications*
- ☐ Limitations due to environmental conditions
- ☐ Reduced hours*

*Please provide further details on these limitations _____

Estimated duration of functional limitations (in days) _____

☐ I have reviewed details of this report with patient Date of 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 of next visit *(d/m/y)* _____

White: Health Care Provider's copy **Yellow:** Worker's copy, to be shared with employer within 24 hours