Workers' Safety and Compensation Board Yukon

FUNCTIONAL ABILITIES FORM

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

WORKER'S INFORMATION

Last Name	
First Name	
Address	
Telephone #	Date of Birth (dd/mm/yy)
Has worker filed claim? ☐ Yes ☐ No	Claim # or part of body
Date of Injury (d/m/y)	

HEALTH CARE PROVIDER'S INFORMATION

Name	
Address	
Telephone #	Fax #
Date of Visit (d/m/y)	Time of Visit

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 *
- ☐ Reduced hours *
- ☐ Other * _____
- ☐ Use of upper extremity *
- ☐ Bending, twisting or kneeling
- ☐ Climbing stairs/ladders
- ☐ Standing *
- ☐ Short term change in environment/location
- ☐ Sitting *
- ☐ Limitations due to medications *
- ☐ Limitations due to environmental conditions

* Please provide further details on these limitations

_____

_____

_____

Estimated duration of functional limitations (in days)

☐ I have reviewed details of this report with patient and have provided him/her with a copy of the report.

I certify that this is a complete and accurate report.

Health Care Provider's Signature _____ Date of next visit (d/m/y) _____

This information is being collected under the authority of the *Workers' Safety and Compensation Act* for the purpose of determining eligibility for benefits. If you have any questions about the collection of this information, please contact the Privacy Officer at WSCB at the above listed address or at (867) 667-5645 or 1-800-661-0443.

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