



Functional Abilities Form

This form is not intended to be used as an **off-work note**. The purpose of this form is to outline **functional abilities and restrictions only**. When completed, this form is used to enable an employer to accommodate an injured worker to remain at, or if absence is unavoidable, to return to work as soon as they are safely able to do so.

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

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

Part A

☐ Worker has no functional limitations

Part B

If applicable, since last visit, worker's functional capacity has:

☐ Improved ☐ Unchanged ☐ Declined

Part C

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

Walking ☐ Less than 30 minutes ☐ About an hour ☐ A few hours ☐ On uneven ground ☐ No limitations ☐ Other (please specify)	Standing ☐ Less than 30 minutes ☐ About an hour ☐ A few Hours ☐ No limitations ☐ Other (please specify)	Sitting ☐ Less than 30 minutes ☐ About an hour ☐ A few hours ☐ No limitations ☐ Other (please specify)	Reaching ☐ Able to reach above shoulder ☐ Able to reach below shoulder ☐ No limitations ☐ Other (please specify)
Bending ☐ Able to forward bend to some % ☐ No limitations ☐ Other (please specify)	Squatting and Kneeling ☐ Able to squat to some % ☐ Able to kneel to some % ☐ No limitations ☐ Other (please specify)	Driving ☐ Able to drive to some % ☐ No limitations ☐ Other (please specify)	Stairs ☐ Able to climb stairs to some % ☐ No limitations ☐ Other (please specify)
Lifting and Carrying ☐ Up to 5kg (10lbs) ☐ Up to 10kg (20lbs) ☐ Up to 20kg (45lbs) ☐ Over 20kg (>50lbs) ☐ No limitations	Hand(s) Use (to type, grip, etc) ☐ Able to use to some % ☐ No limitations ☐ Other (please specify)	Screen Time ☐ Less than 30 minutes ☐ About an hour ☐ A few hours ☐ No limitations ☐ Other (please specify)	Estimated duration of functional limitations (in days):

Additional recommendation or comments (i.e. specific duty consideration and/or ability to do any activities not listed above):

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☐ I have reviewed details of this report with the worker and have provided the worker 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 for the purpose of administering and enforcing the *Workers' Safety and Compensation Act* in compliance with the *Access to Information and Protection of Privacy Act*. If you have any questions about the collection of this information, please contact the board's Privacy Officer at 401 Strickland St., Whitehorse, YT, Y1A 5N8 or call 867-667-5642 or 1-800-661-0443.

Distribution: Copy to Worker (Worker to share with employer within 24 hours).