Workplace Accommodation | Functional and Cognitive Abilities Form - GHC

EMPLOYEE IDENTIFICATION		
Family name:	**Given name:**	**Date of birth (DOB):** MM|DD|YYYY
Address:	**City and Province:**	**Postal code:**
Telephone:	**Company name and division:**	**Employee number:**

EMPLOYEE INSTRUCTIONS

Please have your form completed as follows:

1) Direction and Authorization to Release Medical Information: review, sign your name, and date as indicated
2) Once you have signed the Employee Consent (Part A below), have your Physician or Health Care Provider (i.e. physiotherapist, or chiropractor), complete sections B,C and D in full

PART A: EMPLOYEE CONSENT

The information on this form is being collected by Cowan Benefits Ltd. (CBL) for the purpose of adjudicating and making a recommendation to my employer concerning my eligibility for Accommodation as may be required by statute. I authorize my treating medically qualified health care professional_____ to provide Cowan with the following information relative to my claim. Medical information will be kept confidential by Cowan and will only be provided to my employer as permitted or required by law. It is understood that my employer will be notified concerning my eligibility for accommodation and will be provided with information relevant to my ability to return to work or remain at work and accommodation request. I agree that this authorization is valid throughout the duration of my claim including the resolution of an appeal review. I agree that a photocopy of this authorization or electronic version is valid as the original. I consent and agree that if I choose to provide this form electronically, I understand that by typing my name in the signature box I am signing this form, which has the same effect as if I had provided a handwritten signature.

Signature: _____	Date: _____

PART B: PHYSICIAN/NURSE PRACTITIONER/HEALTH PROFESSIONAL SECTION

Medical impairment (Please provide answers to the following questions)

What is the general nature of the illness or injury related to the accommodation needed/requested?

What is the anticipated duration of the accommodation required?

With modifications to the employee's work or environment would the employee be able to return to work at an earlier date? ☐ Yes ☐ No

Employee Name: **Employer Name:**

Current treatment:
Is your patient under active and continuous medically appropriate care? ☐ Yes ☐ No
Is the condition treatable? ☐ Yes ☐ No

Is your patient following the treatment plan? ☐ Yes ☐ No
If no, why not?

Physician follow-up dates:	**Is there Specialist involvement:** ☐ Yes ☐ No
If yes, date of next specialist visit:	**Future clinical tests and dates:**

PART C: FUNCTIONAL CAPACITIES - Please document your patient's estimated or demonstrated **physical capacities**.

Occasional = Up to 1/3 of an 8-hour workday
Frequent = 1/3 to 2/3 of an 8-hour workday
Constant = 2/3 or greater of an 8-hour workday

Task (please check the appropriate box)	**N/A**	**Occasional**	**Frequent**	**Constant**	**Comment** (please specify limitations)
Sitting	○	○	○	○	
Standing	○	○	○	○	
Walking	○	○	○	○	
Kneeling/crouching/squatting	○	○	○	○	
Bending/twisting/turning	○	○	○	○	
Stair/ladder climbing	○	○	○	○	
Pushing/pulling	○	lbs/kg	lbs/kg	lbs/kg	
Two-handed carrying	○	lbs/kg	lbs/kg	lbs/kg	
One-handed carrying	○	lbs/kg	lbs/kg	lbs/kg	
Reaching forward	○	○	○	○	
Reaching overhead	○	○	○	○	
Gripping/grasping	○	○	○	○	
Lifting floor to waist	○	lbs/kg	lbs/kg	lbs/kg	
Lifting waist to shoulder	○	lb/kg	lbs/kg	lbs/kg	
Lifting above shoulder	○	lb/kg	lbs/kg	lbs/kg	

Please note any other physical restrictions not identified above, including specific limitations and accommodation suggestions:

Employee Name: **Employer Name:**

Current cognitive and psychosocial restrictions and limitations, if applicable

Cognitive limitation	N/A	Mild	Moderate	Severe
Concentration/attention	○	○	○	○
Memory	○	○	○	○
Multitasking	○	○	○	○
Planning	○	○	○	○
Problem-solving	○	○	○	○
Decision making/judgement	○	○	○	○
Communication	○	○	○	○
Psychosocial limitations	**N/A**	**Mild**	**Moderate**	**Severe**
Interactions with the public	○	○	○	○
Cooperation with co-workers	○	○	○	○
Conflict resolution	○	○	○	○
Emotional regulation	○	○	○	○
Motivation/energy levels	○	○	○	○

Comments (Please specify nature of the restriction and limitation and any suggestions for accommodation):

PART D: ACCOMMODATION OUTCOME

If you wish, please provide any comments and/or accommodation recommendations here:

Physician/Nurse Practitioner/Health Professional Identification

Name:		**License Number:**	
Telephone:	**Fax:**	**Signature:** _____	**Date:**

Fax or email the completed form to:
Cowan Benefits Ltd., Return to Health®
225 King George Rd., Brantford ON N3R 7N7
Email: rthclient.service@cowangroup.ca
Fax: 1-866-508-4111