*The purpose of this form is to; provide restrictions to the employer to enable the worker to return to alternate or modified work as soon as possible, to identify suitable work that is both productive and safe, and to provide work assignments that honour the outlined restrictions. If the employer is unable to offer work that is appropriate to the outlined restrictions the worker will be off work.*

**Section A: Employee Information *(to be completed by Employee)***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Print Employee Name Department Occupation/Duties*

*I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Employee Signature), authorize the release of the following information to my employer to assist in an early and safe Return-to Work. Dated (dd/mm/yy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Section B: Restrictions, Limitations & Precautions *(to be completed by Health Care Professional).*** Please take the time to consider the following so we may ensure the duties offered meet the needs of the employee.

|  |  |
| --- | --- |
| **Strength**  lifting, carrying, pulling or pushing objects to a maximum of:  🞏 5 Kilograms 10 Kilograms 20 Kilograms  🞏 avoid firm or repetitive right-hand grip  🞏 avoid firm or repetitive left-hand grip  🞏 no strength restrictions | **Safety and Balancing**  🞏 avoid work on slippery or uneven surfaces  🞏 avoid the operation of vehicles or equipment  🞏 avoid work at heights  🞏 avoid stairs  🞏 avoid work in areas requiring full peripheral vision  🞏 no balancing or safety restrictions |
| **Postures and Tasks**  🞏 avoid prolonged bending and/or twisting of the torso  🞏 avoid prolonged kneeling, squatting, or crawling  🞏 avoid overhead or above shoulder work  🞏 restrict standing/walking to \_\_\_\_\_\_\_ hrs. per shift  🞏 provide changes between standing, sitting and walking  🞏 no posture or task restrictions  **Work Hours**  🞏 restrict work hours to \_\_\_\_\_\_\_ hrs. per shift/week  🞏 no restrictions - full time hours | **Environmental Factors**  🞏 avoid work in extreme temperatures  🞏 avoid work in dust, chemical vapors, etc.  🞏 avoid work with vibrating hand tools  🞏 restrictions on PPE – respirator, hard hat, safety glasses  fall protection, etc.  🞏 no environmental concerns  **Medical Treatment**  🞏 Employee required to wear assistive devices or braces  🞏 Employee involved with treatment and/or  medications that may affect his/her ability to work? |

**Can this employee safely return to work if the restrictions are accommodated 🞏 Yes 🞏 No**

**Expected date for return to full duties \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other Medical Restrictions/or Comments**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Health Care Professional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name, Address and Telephone *(please print)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Note: A fee of *enter amount here* will be provided for completion of this form please invoice to the attention of the Human Resources Department at: *P.O. BOX XXXX Saskatoon, Saskatchewan, enter Postal Code (306) XXX-XXXX Fax (306) XXX-XXXX*****Attention Safety Department/Human Resources Department**