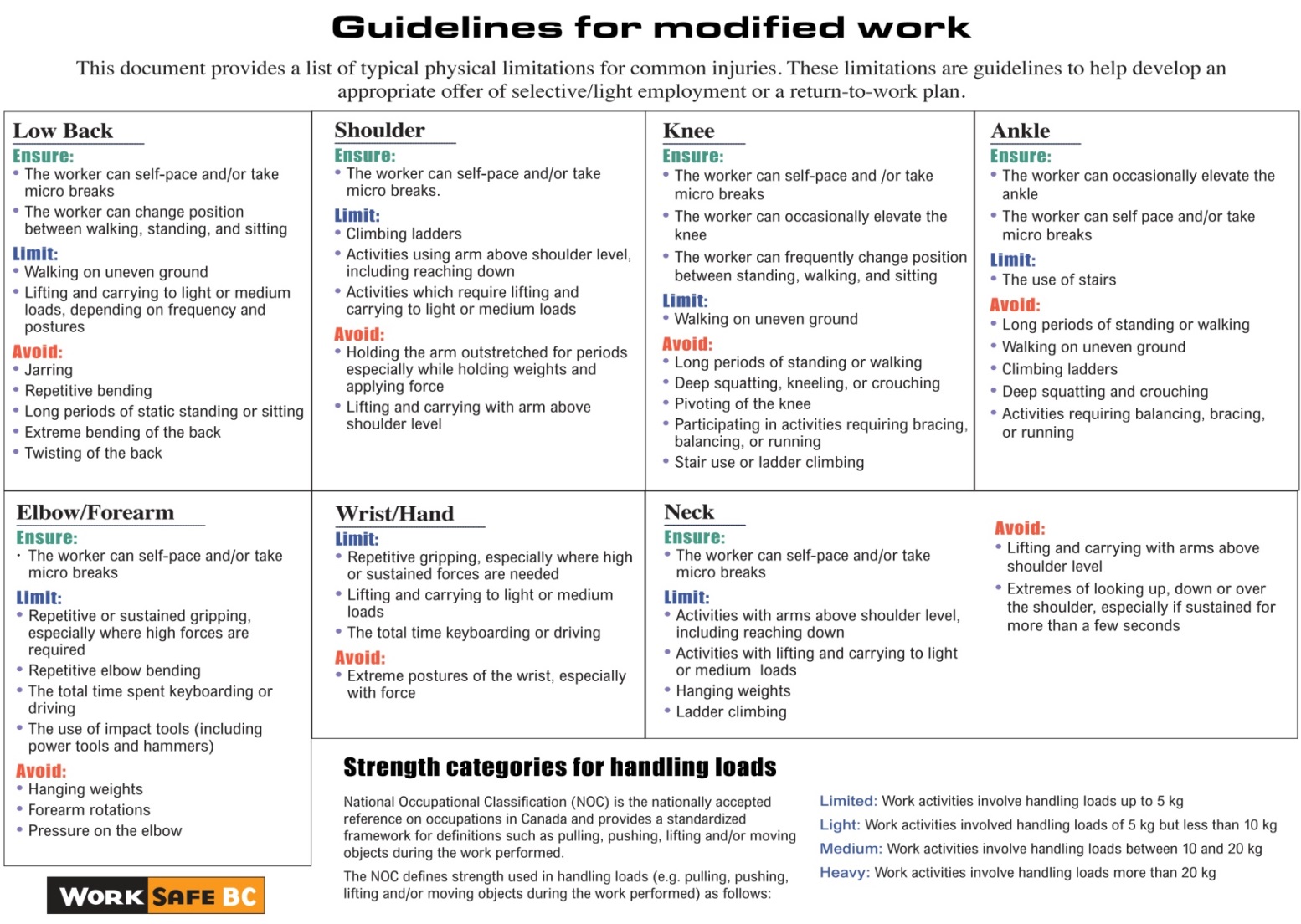
# Form C: Physician Assessment — Return-to-Work Planning

|  |  |
| --- | --- |
| Employee Authorization to Release Information I, (print full name), hereby authorize my attending physician to release the information below to my employer, [EMPLOYER], for the purpose of planning my work duties as part of [EMPLOYER’S] return-to-work program.    Employee’s signature Date | |
| Areas of injury/body parts | Does the employee have any functional limitations or restrictions as a result of the injury?  🞎 No  🞎 Yes, please see below to provide more information |
| Next appointment date | If the employee has limitations or restrictions, how long do you recommend these considerations?  days |

Please complete the following chart *or* circle the appropriate standard restrictions in the *Guidelines for Modified Work* (see next page).

## Physical Capacity

| **Capacity** (Complete only the sections where there is a limitation or restriction related to an injury or illness) | **Effort**  (If applicable, for example, 2 kg) | **Frequency**  (If applicable) |
| --- | --- | --- |
| Standing |  |  |
| Walking |  |  |
| Sitting |  |  |
| Lifting from floor to waist |  |  |
| Lifting from waist to shoulder |  |  |
| Lifting overhead |  |  |
| Bending or twisting |  |  |
| Pushing or pulling |  |  |
| Vibration |  |  |
| Environmental exposure |  |  |
| Substance exposure |  |  |
| Gripping |  |  |
| Precision work with hands |  |  |
| Speaking |  |  |
| Driving |  |  |
| Operating motorized equipment |  |  |
| Quick movement |  |  |
| Speech |  |  |
| Hearing |  |  |
| Vision |  |  |
| Smell |  |  |
|  |  |  |
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|  |  |  |



Please provide the completed form to your patient at the end of the appointment.

Please fax to [EMPLOYER] at or email at \_\_ and fax a copy to WorkSafeBC at 1 888 922‑8807 or 604 233-9777.

Physician’s signature Date

Physician’s name (print) Telephone number