TORONTO

Return to Work Information

All City of Toronto Employees (except Local 79)

Section A: To be completed by the worker or employer

Worker information		
WSIB Claim Number		Employee Number
First Name	Last Name	Home Telephone Number
Home Address (Street Number, Street Name, Suite/Unit Number, City/Town, Province, Postal Code)		
Date of Injury/Onset of Illness (yyyy-mm-dd)		Area of Injury(if applicable)
Job at time of Injury/Illness		
Division	Work Address (Street Number, Street Name, Suite/Unit Number, City/Town, Province, Postal Code)	
Supervisor Name (First, Last)	Work Telephone Number	Alternate Telephone Number

Section B: To be completed by health professional and returned to the worker:

☐ **Initial Form** ☐ **Follow-Up Form**

Injury/Illness Information	
Nature of Injury/Illness: ☐ medical illness ☐ injury (please indicate)	
Estimated Recovery Time:	Is Complete Recovery Expected: ☐ Yes ☐ No
Please specify further treatment required, if any:	

Ability to Work (check only one)

☐ Able to return to work immediately without restrictions

☐ Able to return to modified duties. Modified duties arerecommended for_____days or_____weeks

☐ Unable to participate in any work, including modified duties for_____days or_____weeks

If the worker has any functional limitations please check the necessary precaution(s)

Strength Demands	**Abilities**	**Abilities**	**Abilities**
☐ Lifting floor to knuckle	☐ No loads >20 kg	☐ No loads >10 kg	☐ Occasional lifting only
☐ Lifting knuckle to chest	☐ No loads >20 kg	☐ No loads >10kg	☐ Occasional lifting only
☐ Lifting above chest	☐ No loads >20 kg	☐ No loads >10kg	☐ Occasional lifting only
☐ Carrying	☐ No loads >20 kg	☐ No loads >10	☐ Occasional carrying only
☐ Pushing/Pulling	☐ No heavy pushing/pulling	☐ Occasional pushing/pulling	☐ Avoid pushing/pulling
☐ Hand Function	☐ Avoid repetitive hand motion	☐ No strong gripping	☐ Avoid gripping
☐ Reaching	☐ No prolonged overhead reaching	☐ No overhead reaching	☐ Avoid any reaching
☐ Sitting	☐ No prolonged sitting		
☐ Standing	☐ No prolonged standing	☐ Avoid standing	
☐ Walking	☐ No prolonged walking	☐ Avoid uneven ground	☐ Avoid walking
☐ Climbing stairs/ladders	☐ Occasional climbing only	☐ No ladder climbing	
☐ Stooping/Bending	☐ No prolonged stooping/bending	☐ Occasional stooping/bending only	☐ Avoid stooping/bending
☐ Crouching/Kneeling	☐ No prolonged crouching/kneeling	☐ Occasional crouching/kneeling only	☐ Avoid crouching/kneeling

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Behavioural/Cognitive Restrictions and/or Limitations

Complete this section if the medical condition has resulted in a restriction/limitation. Check all that apply

☐ Yes, see below. ☐ Not Applicable

Behavioural/Cognitive Demands			
☐ Ability for self-supervision	☐ Performance of multiple tasks	☐ Tolerance of confrontational situations	☐ Numeric skills
☐ Ability to supervise others	☐ Tolerance to distracting stimuli	☐ Responsibility and accountability	☐ Communication
☐ Ability to tolerate time pressures	☐ Ability to work cooperatively	☐ Reading literacy	☐ Memory
☐ Ability to concentrate and attend to detail	☐ Tolerance of emotional situations	☐ Writing literacy	☐ Computer literacy

Are there are contraindications to the testing process if the City's Disability Management staff recommend this employee for functional testing?

☐ Yes ☐ No

Comments/Specific Limitations: Please describe any additional related precautions or medical restrictions pertaining to: effects of medication, driving vehicles or operating equipment, physical exertion, vibration, work environment, work hours.

_____

_____

Health Professionals Information (PLEASE PRINT):

Name (First, Last)		Position/Title
Address (Street Number, Street Name, Suite/Unit Number, City/Town, Province, Postal Code)		
Telephone Number		Date (yyyy-mm-dd)
Exam Date (yyyy-mm-dd)	Next Appointment Date (yyyy-mm-dd)	
Health Professionals Signature		

Section C: Worker Consent (to be completed by the worker)

I authorize the health professional involved with my treatment to provide me, my employer, and the Workplace Safety and Insurance Board (if applicable) this completed form containing information about any limitations/restrictions affecting my ability to return to work.

X _____

Date:

Human Resources collects personal information on this form under the legal authority of the City of Toronto Act 2006, S.O. 2006, Chapter 11, Schedule A, s. 136 (c), the Workplace Safety and Insurance Act, 1997, S.O. 1997, Chapter 16, Schedule A, s 40(1-2) and the Collective Agreement between Canadian Union of Public Employees, Local 416 and City of Toronto, Article 46.The information is used to administer return to work process.
Questions about this collection can be directed to the Director Occupational, Health & Safety, Human Resources, Metro Hall, 55 John Street, 5th floor, Toronto, Ontario M5V 3C6 or by telephone at 416-392-5028.