Fleming College

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# FUNCTIONAL ABILITIES FORM (FAF)

## to support employee medical accommodation

CONFIDENTIAL

Worker's Authorization:

I, _____(print name of employee), hereby authorize

**Attending Health Care Professional's Name, Full Address & Telephone** *(Please print or use business stamp below)*

The release of the information in this document relevant to my functional and cognitive capabilities with respect to my job duties at Fleming College, to my Supervisor or Manager, Human Resources Consultant(s), and Union/Association Representative, as applicable. I give my permission for this information to be utilized for the purposes of providing information about my functional abilities and restrictions with respect to my job duties, in order to support the accommodation of my disability or health condition, so that I may work in a healthy and safe manner.

The information on this form will be treated as personal information in accordance with the provisions of the Freedom of Information and Protection of Privacy Act and personal health information in accordance with the Personal Health Information Protection Act. The College shall maintain the confidentiality of this information, and will not disclose it to any additional third parties, other than noted above, without my written consent, except where disclosure is required by law.

I declare that my consent has been given voluntarily. I understand that I may withdraw my consent at any time.

Employee's Signature Date:

MEDICAL ASSESSMENT: Choose one of the following:

- ☐ Employee is able to work without restrictions on: _____ (date) - no further information required
- ☐ Employee is able to work with restrictions on: _____(date) - please complete Sections B &C on following pages

  Prognosis: Estimated duration of restrictions _____ days or _____ weeks.

  Re-assessment date: _____

- ☐ Employee is totally disabled and unable to work due to a medical condition.

  Re-assessment date: _____

_____

**HEALTH CARE PROFESSIONAL'S SIGNATURE** **DATE**

**Note to Health Care Provider:** Fleming College provides accommodation to disabled, ill or injured employees. The information on this form will be used to help the employee return to work / be accommodated

1. Please do NOT provide diagnosis, medication, or treatment
2. Please base your responses on objective medical findings.
3. Only complete those items which clearly and directly apply to the employee's condition

SECTION B – Some restrictions are required. The employee will require medical accommodation for return to work.

**Please Also Complete The Abilities & Restrictions Assessment In Section C.**

Working hours Restrictions: recommendation for Work Hours *(check the applicable boxes)*

☐ **No restriction** to normal weekly/daily hours

**OR** – please complete sections in the following pages associated with medically substantiated restrictions:

☐ **Reduced hours/day:** (ex. maximum # of hrs/day, start & end times, etc)

_____

☐ **Reduced hours/week:**

Recommended number of hours per week _____

Note - for Full-time Faculty, please specify: _____ % of 44 hours per week

☐ **Reduced days per week:** (**e.g. work 3 days/week – Mon/Wed/Friday etc.**)

Days per week: **(Please circle days to work) S M T W T F S**

☐ Gradual return to work: (insert specific details and timelines):

_____

_____

_____

Comments: _____

_____

_____

_____

**SECTION C – ABILITIES & RESTRICTIONS ABILITIES ASSESSMENT: Please provide the applicable musculoskeletal, functional and/or sensory/cognitive restrictions to assist with providing appropriate accommodation to enable the employee to remain at work.**

**Musculoskeletal Restrictions:** Please check all restrictions / limitations that apply and provide comments.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | | Head/ Face | | | | | Comments |
| ☐ | Left | Ears | ☐ | Right | | | |
| ☐ | Left | Eyes | ☐ | Right | | | |
| ☐ | | Neck | | | | | |
| ☐ | | Nose | | | | | |
| ☐ | Left | Upper Back | | | | | |
| ☐ | Left | Middle Back | | | | | |
| ☐ | Left | Lower Back | | | | | |
| ☐ | Left | Chest | | | | | |
| ☐ | Left | Abdomen | | | | | |
| ☐ | | Pelvis | | | | | |
| ☐ | | Tail Bone | | | | | |
| ☐ | Left | Shoulder | ☐ | Right | | | |
| ☐ | Left | Upper Arm | ☐ | Right | | | |
| ☐ | Left | Elbow | ☐ | Right | | | |
| ☐ | Left | Forearm | ☐ | Right | | | |
| ☐ | Left | Wrist | ☐ | Right | | | |
| ☐ | Left | Hand | ☐ | Right | | | |
| ☐ | Left | Finger(s) | ☐ | Right | | | |
| ☐ | Left | Hip | ☐ | Right | | | |
| ☐ | Left | Thigh | ☐ | Right | | | |
| ☐ | Left | Knee | ☐ | Right | | | |
| ☐ | Left | Lower Leg | ☐ | Right | | | |
| ☐ | Left | Ankle | ☐ | Right | | | |
| ☐ | Left | Foot | ☐ | Right | | | |
| ☐ | Left | Toe(s) | ☐ | Right | | | |
| Other: | | | | | | | |

**Functional Restrictions**: Please check all restrictions / limitations that apply and provide comments.

| ☐ **Walking:** | ☐ **Standing:** | ☐ **Sitting:** | ☐ **Lifting Floor to Waist:** |
|---|---|---|---|
| ☐ Up to 100 feet(30m) only<br>☐ 100-200 feet (31-60m) only<br>☐ Other )please specify below) | ☐ Can only stand for up to 30 minutes at a time<br>☐ Can only stand 30-60 minutes at a time<br>☐ Other (please specify below) | ☐ Can only sit for up to 30 minutes at a time<br>☐ Can only sit 30-60 minutes at a time<br>☐ Other (please specify below) | ☐ Under 5kg / 11lbs<br>☐ Between 5-20kg / 11-44lbs<br>☐ Over 20kg / 44lbs<br>☐ Other (please specify below) |

| ☐ **Lifting waist to shoulder** | ☐ **Lifting above the shoulder** | ☐ **Stair climbing** | ☐ **Ladder climbing** |
|---|---|---|---|
| ☐ Under 5kg / 11lbs<br>☐ Between 5-20kg / 11-44lbs<br>☐ Over 20kg / 44lbs<br>☐ Other (please specify below) | ☐ Under 5kg / 11lbs<br>☐ Between 5-20kg / 11-44lbs<br>☐ Over 20kg / 44lbs<br>☐ Other (please specify below) | ☐ Under 5 steps<br>☐ 5-10 steps<br>☐ Other (please specify) | ☐ 1-3 steps<br>☐ 4-6 steps<br>☐ Other (please specify) |

| | | |
|---|---|---|
| ☐ **Bending / twisting / repetitive movement of: (please specify)** | ☐ **Working at / or above shoulder: (please specify)** | ☐ **Pushing / pulling with:**<br>☐ Left arm ☐ Right arm<br>☐ Other (please specify) |
| ☐ **Limited use of hand(s) or wrist(s):**<br>☐ Left Type / Keyboard ☐ Right<br>☐ Left Write ☐ Right<br>☐ Left Gripping ☐ Right<br>☐ Left Pinching ☐ Right<br>☐ Other | ☐ **Unable to:**<br>☐ Operate motorized equipment<br>☐ Operate machinery / tools<br>☐ Work at heights | ☐ **Must avoid:**<br>☐ Chemical Exposure<br>☐ Environmental conditions<br>☐ Temperature / heat & cold<br>☐ Exposure to vibration, motion, balance, etc.<br>Please provide further information under Additional Comments below (ex. types of chemicals / environmental conditions / temperatures to avoid. |
| ☐ **Medications**: list potential side effects from medications which may interfere with the safety of the employee and/or their co-workers: (please specify **without** identifying medications)**:** | | |

**Additional comments (please include objective medical information for restrictions without diagnosis):**

**Cognitive & Sensory Restrictions:** Please check all restrictions / limitations that apply and provide comments.

| | | |
|---|---|---|
| ☐ **Sight: (please specify)** | ☐ **Speech: (please specify)** | ☐ **Hearing: (please specify)** |
| ☐ **Memory: (please specify)** | | **Tolerance to deadlines:**<br>☐ Cannot deal with deadline pressure<br>☐ Can occasionally deal with deadlines<br>☐ Can deal with recurring deadlines |
| **Attention to detail:**<br>☐ Concentration on detail is limited<br>☐ Can concentrate on detail with occasional breaks<br>☐ Can tolerate working with others for short periods of time. (please specify) | **Performance of multiple tasks:**<br>☐ Only able to deal with one task at a time<br>☐ Can handle multiple tasks: but requires additional time | **Tolerance to distractions:**<br>☐ Needs quiet, no distractions<br>☐ Can cope only with small degree of distraction |
| **Ability to work with others:**<br>☐ Unable to tolerate working alone<br>☐ Can only tolerate working alone<br>☐ Can tolerate working with others for short periods of time (please specify) | **Ability to manage conflict:**<br>☐ Unable to cope with conflict<br>☐ Has moderate ability to cope with conflict | **Supervision of others:**<br>☐ Unable to supervise<br>☐ Can supervise a small group of people: (please specify) |

**Additional comments (please include objective medical information for restrictions without diagnosis):**



**Attending Health Care Professional's Signature:** **Date:**