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| --- |
| Administrative Information (please print): |
| Employee’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Regular Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Treating Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Physical Restrictions: |
| Provided By: ☐ WSIB (authorized)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Doctor ☐ Specialist  Documentation: ☐ Functional Abilities Form ☐ Form 7 ☐ Doctor’s Note  ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Proposed Duration of Restriction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Actual Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| LIGHT DUTIES/MODIFIED JOB DESCRIPTION |
| (The returning worker must understand that he/she is not to exceed the restrictions/limitations detailed by the treating physician/WSIB physician. As necessary, this Modified Job Description will be further modified to reflect the injured worker’s (dis)abilities.) |
| Job Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Conditions: |
|  |
| Weights and Sizes: |
|  |
| Job Tasks: |
|  |
| List Essential Duties: |
|  |
| List Non-Essential Duties: |
|  |
| Additional Notes Attached: ☐ Yes ☐ No |