Employee Name: _____ **Date of Exam:** _____

Name of Doctor: _____

☐ **Able to return to full duties without restrictions**

1. Please indicate Abilities that apply. Include additional details in section 3

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify

Sitting
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ 15 -20 kilograms

Lifting from waist to shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ 15 -20 kilograms

Lifting from shoulder and above:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ 15 -20 kilograms

Ladder climbing:
- ☐ Full abilities
- ☐ 1 - 3 steps
- ☐ 4 - 6 steps
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

2. Please indicate Restrictions that apply. Include additional details in section 3

☐ Bending/twisting repetitive movement of (please specify)

☐ Work at or above shoulder activity:

☐ Chemical exposure to:

☐ Environmental exposure to: (e.g. heat, cold, noise or scents)

☐ Potential side effects from medications (please specify)
Do not include names of medications.

☐ Limited pushing/pulling with:
- ☐ Left arm
- ☐ Right arm
- ☐ Other (please specify)

☐ Limited use of hand(s):

	Left		Right
	☐	Gripping	☐
	☐	Pinching	☐
	☐	Other (please specify)	☐

3. Additional Comments on Abilities and/or Restrictions. _____

_____

_____

_____

_____

4. From the date of this assessment, the above will apply for approximately:

☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Next date of Review: (DD/MM/YYYY) _____

Doctor's Signature: _____ **Date:** _____

This form is your responsibility to have filled out by your doctor.