lifemark
HEALTH GROUP

DISABILITY/SICK LEAVE ATTENDING PHYSICIAN'S STATEMENT RETURN TO WORK

Please complete this form in full and fax directly to 1-403-569-0196

Alternatively, you may send via mail to:
Lifemark Disability Management
Suite 70, 2121 Street NE Calgary, Alberta T1Y 7H8

Part 1: General Information – Employee to Request Physician to Complete

Employee Name:	**Employee Birthdate:**
Date when illness or injury first commenced: **Date:** ______________________ Month / Day / Year	**Date of your first review for this current illness or injury:** **Date:** ______________________ Month / Day / Year
Date of your next review **Date:** ______________________ Month / Day / Year	**Are there non-medical factors contributing to this absence? If so, are they being addressed (i.e. EAP)?**
Describe nature of current illness or injury:	**Prognosis for recovery from limitations, and estimated return to work date in any capacity:** **Estimated duration of absence:**
Is there a prescribed treatment plan? **Yes** ☐ **No** ☐ **If yes, please list date treatment began** **Date:** ______________________ Month / Day / Year	**Is patient complying with prescribed treatment?** **Yes** ☐ **No** ☐ **Could patient remain/return to work while following their prescribed treatment?** **Yes** ☐ **No** ☐
Expected duration of restrictions:	**Is complete recovery expected?** **Yes** ☐ **No** ☐
Date patient is medically fit to return to work to full hours and duties?	**Date patient can engage in modified duties/hours:** **Work schedule restrictions and recommendations:** **(see Part 2 below)**

A photocopy, facsimile or an electronic version of this document shall be valid as the original

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The University of Saskatchewan has a recognized Modified Work Program to assist ill and injured employees to return to work in a safe and timely manner. This program takes an active role in rehabilitating employees by incorporating alternate and/or modified work in the workplace. The University of Saskatchewan is able to accommodate temporary disabilities assisting in restoring normal function, recovery and returning the employee to their own job as soon as possible.

PART 2: Current Functional Abilities (please circle) – to be completed by Physician

Able to Walk (without rest)	Yes - No Limitations	Distances up to 30 m	Distances up to 15m	Very Minimal / None
Able to Stand (without rest)	Yes - No Limitations	30 - 60 Mins	15 to 30 mins	Very Minimal / None
Able to Sit	Yes - No Limitations	30 - 60 Mins	15 to 30 mins	Very Minimal / None
Able to Lift floor to waist	Yes - No Limitations	Up to 20 kgs (approx 55)	Up to 10 kgs (approx 25)	Very Minimal / None
Able to Lift waist to shoulder	Yes - No Limitations	Up to 20 kgs (approx 55)	Up to 10 kgs (approx 25)	Very Minimal / None
Able to Climb (stairs and/or ladder)	Yes - No Limitations	Short Flights	A Few Steps	Very Limited / None
Able to Grip	Yes - No Limitations	Frequently	Occasionally	Very Minimal / None
Able to Type	Yes - No Limitations	Frequently	Occasionally	Very Minimal / None
Able to Write	Yes - No Limitations	Frequently	Occasionally	Very Minimal / None
Able to Bend / Twist	Yes - No Limitations	Frequently	Occasionally	Very Minimal / None
Repetitive Movement	No Limitations	Frequently	Occasionally	Very Minimal / None
Above Shoulder Activity	No Limitations	Frequently	Occasionally	Very Minimal / None

Memory/Concentration	No Limitations	Mild Restriction	Moderate Restriction	Severe Restriction
Energy/Stamina	No Limitations	Mild Restriction	Moderate Restriction	Severe Restriction
Interaction with others	No Limitations	Mild Restriction	Moderate Restriction	Severe Restriction
Ability to Multi-Task	No Limitations	Mild Restriction	Moderate Restriction	Severe Restriction
Decision Making	No Limitations	Mild Restriction	Moderate Restriction	Severe Restriction

Driving	Unrestricted	Partially Restricted **(please specify)**	Completely

Other limitations: (please specify)

Expected duration of limitations:	_________Days	1 – 2 weeks	3 – 4 weeks	_________weeks
If hours are restricted please indicate	____________**Hours**	**Duration of restrictions:**	___________ Days / Weeks (Please circle)	

Expected Return to Full Duties:	**Date (mm/dd/yy):**

PHYSICIAN'S NAME	**SPECIALITY**
PHYSICIAN'S SIGNATURE *I verify that all 5 parts of this form have been reviewed and completed*	**DATE**

Physician / Office Address Stamp (required)