REGINA PUBLIC SCHOOLS
PHYSICIAN'S ASSESSMENT FORM

EMPLOYEE INFORMATION:

Employee Name: _____ Email: _____

Employee Number: _____ Phone: _____ School: _____

Employee's Authorization for Release of Information and/or Request for Workplace Accommodation

I, _____, hereby authorize my health care provider/insurance provider to complete this form on the understanding that I will release this medical certificate to my employer.

Employee Signature: _____ Date: _____

***Please note that our Employee Assistance Program (1-844-880-9142) is available to all employees.**

Attention Licensed Health Care Professional:

Regina Public Schools is committed to ensuring our employees are provided with the opportunity to be accommodated where legitimate medical restrictions exist. Workplace accommodations can include leaves of absence as well as facilitating available work that meets medical restrictions and/or limitations. The purpose of this form is to provide information about our employee's medical restrictions and/or limitations for the purpose of establishing appropriate workplace accommodations.

We are not asking for diagnosis information. We ask that you complete the form based on your objective medical assessment. Please note the College of Physicians and Surgeons of Saskatchewan policy on certifying illness and/or assessing capacity for work advises that it is:

> *"The responsibility of the physician is to do an objective evaluation and to report the impact of an injury/illness and the limitations that the patient/worker's injury/illness places on their ability to perform certain functions. …*
> *It is the responsibility of the employer to manage the worker's return to modified or usual work duties with the benefit of objective professional input from physicians and/or other health care professionals."*

The information in this report is considered confidential. Any charge for completion of this form is the responsibility of the employee.

HEALTH CARE PROVIDER INFORMATION (Please print):

Name: _____ Date: _____

Address: _____ Phone: _____

Signature: _____ Email: _____

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☐ See attached physical/functional demands worksheet for the employee's position.
☐ See attached job description for the employee's position.

Section B – Functional/Physical Restrictions. Mark ✓ only those relevant boxes that apply.

Functional/Physical	Restriction/ Limitation	Provide specific details of each restriction or limitation identified
Sitting / Standing / Walking	☐	
Lifting / Carrying / Pushing / Pulling	☐	
Climbing stairs and ladders / Balance	☐	
Crouching / Crawling / Kneeling / Bending	☐	
Reaching / Gripping and Fine Dexterity	☐	
Repetitive activity / Twisting / Turning / Sustained postures	☐	
Vision / Hearing / Speech	☐	
Environmental allergens/sensitivities (please describe)	☐	
High-risk medical condition	☐	
Vulnerable	☐	

Section C – Cognitive/Psychological. Mark ✓ only those relevant boxes that apply and outline specific details about the restriction or limitation that is identified.

Cognitive/Psychological	Restriction/ Limitation	Provide specific details of each restriction or limitation identified
Cognition (Thinking/Reasoning)	☐	
Critical decision making (ability to make decisions related to safety of self and others)	☐	
Sustained Concentration and Focus (ability to follow directions and to stay on task to completion)	☐	
Stress tolerance (ability to withstand normal job pressures, to work with challenging individuals, to make deadlines and target dates, to multi-task or have multi interruptions, and/or to respond to change)	☐	
Interpersonal functioning (problem solving, conflict resolution, supervising others)	☐	
Stamina/Pace (ability and energy to perform tasks/duties)	☐	

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Section D – Medications and/or Treatment Plan. Mark ✓ only those relevant boxes that apply and outline specific details about the restriction or limitation that is identified.

Has the employee been prescribed medications and/or treatments that may affect the employee's ability to perform some or all of the assigned duties or which could affect the safety of the employee himself or others?	
☐ Yes (please explain)	☐ No
Is employee following their prescribed plan? ☐ Yes ☐ No	

Section E – Prognosis for Recovery/Graduated Return to Work/Reassessment

In my *opinion*, these restrictions or limitations are:	
☐ Temporary. If temporary, for how long?	☐ Permanent

Would a graduated return to work be recommended?	
☐ Yes. If yes, over what period of time?	☐ No

Date of next reassessment (indicate n/a if not applicable): _____

Please return completed form to:
Regina Public Schools Workplace Health and Wellness
1600 4th Avenue, Regina, SK S4R 8C8
Phone: 306-523-3162
Email: wellness@rbe.sk.ca