A Division of the Ability Resource Association

*#20*_____

To Be Completed By Your *DOCTOR or MENTAL HEALTH THERAPIST*

Ability Employment Service matches people with a medical condition and/or disability with meaningful employment opportunities in our community. We ask for your assistance in achieving this goal by taking a few minutes to answer the following:

Name of Individual: _____

How long have you known this person?_____

What is the individual's disability/medical concern? _____

_____

Is the individual able to work at this time? **YES** ☐ **NO** ☐

If no, please indicate your best estimate of how long this person may need before starting employment (i.e. weeks, a month, or longer)

_____

_____

Check the amount of work this person is best suited for: ***Please check all that apply and comment.***

_____

_____

_____

_____

_____

_____

☐ **Part-time Employment:** can work **Part Time** with minimal support

☐ **Full-time Employment:** can work **Full Time** with minimal support

Do you know of any restrictions in mobility the person has or accommodations they may require to be successful in a work environment? (i.e. cannot work shift work or lifting restrictions) _____

_____

_____

Additional Comments: _____

_____

_____

_____

Signature: _____ **Date:** _____

***Please print your* name:** _____

Name of Clinic _____ **Phone #:** _____

☐ Family Doctor/Specialist

☐ Registered Therapist/Psychiatrist

I, _____ hereby authorize the release of medical information concerning _____ to the Ability Resource Association and/or Ability Employment. This information will relate directly to and is necessary for the operation and activities provided by the service.

Date: _____

We thank you for your time and assistance in helping us best serve this person.

Ability Employment
416 - 8 Street South
Lethbridge AB T1J 2J7
Phone: (403) 317-4550 Fax: (403) 317-4552

Reviewed: May 2018, July 2021
Revised: May 2019, March 2020, January 2022
Client Services – Appendix 25