Medical Ability to Work Form

(To be completed by attending physician.)

The purpose of this form is to provide the employer with the necessary information that they need to help make decisions about accommodating the patient or assessing if the patient can work without restriction.

Notes to physician

1. This form is not intended for Workers' Compensation Board (WCB) purposes. For a work-related injury or illness, the required WCB forms must be completed.
2. This form **does not replace** forms related to an employee's ability to work that are required by:
   - Workers' Compensation Board,
   - Third-party insurers, or
   - Employer-funded medical benefit plans.
3. When completing this form, disclose only information necessary to meet the purpose of the form. Typically, it is not necessary to provide a diagnosis or treatment information.

Physician's name and address (typewritten or printed)

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____

I saw ____ **on** ____________________**.**

(Print patient's name) (Date)

This patient is medically able to work without limitations or restrictions. ____________________

(Date)

My opinion is based on the factors indicated below:

☐ Information provided by the patient

☐ My examination of the patient and my assessment of the findings and health information

____ ______________________________

(Physician's Signature) (Date)

NOTE: Completion of this form is an uninsured medical service. There may be a fee to the patient for completion of this form.

OBTAINING AND RESPONDING TO MEDICAL INFORMATION IN THE WORKPLACE