Medical Ability to Work Form

(To be completed by attending physician)

The purpose of this form is to provide the patient with the necessary information that they need to give to their employer to help the employer make decisions about accommodating the patient, providing disability leave, 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. Where choices are indicated below, please mark your selection.
4. Please sign and date and keep a copy of this form.

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)

Dr. Sonali Jain

1011 Bowles Ave, Ste 300, Fenton, MO 63026

I saw Ca _____ on _____.
(Print patient's name) (Date)

This patient is medically able to work without limitations or restrictions _____.
(Date)

Restrictions or limitations

In my opinion, these restrictions or limitations are:

☐ Temporary:
- ☐ _____ days
- ☐ less than 2 weeks
- ☐ 2 to 4 weeks
- ☐ 4 to 6 weeks
- ☐ 6 weeks to 3 months
- ☐ more than 3 months

☐ Permanent

Date of next appointment is (indicate **n/a** if not applicable) _____.
(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

I have provided this form to the patient named above.

_____ _____
(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.