



# Functional Abilities

Worker's Last Name	First Name	Claim Number
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Identify the worker's overall abilities and restrictions.

## A. Abilities and Restrictions

1. Please indicate <b>Abilities</b> that apply. Include additional details in section 3.																
Walking: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 100 metres <input type="checkbox"/> 100 - 200 metres <input type="checkbox"/> Other (please specify)	Standing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15 - 30 minutes <input type="checkbox"/> Other (please specify)	Sitting: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 minutes - 1 hour <input type="checkbox"/> Other (please specify)	Lifting from floor to waist: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (please specify)													
Lifting from waist to shoulder: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (please specify)	Stair climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 steps <input type="checkbox"/> 5 - 10 steps <input type="checkbox"/> Other (please specify)	Ladder climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> 1 - 3 steps <input type="checkbox"/> 4 - 6 steps <input type="checkbox"/> Other (please specify)														
2. Please indicate <b>Restrictions</b> that apply. Include additional details in section 3.																
<input type="checkbox"/> Bending/twisting repetitive movement of: (please specify)	<input type="checkbox"/> Work at or above shoulder activity:	<input type="checkbox"/> Chemical exposure to:	<input type="checkbox"/> Environment exposure to: (e.g. heat, cold, noise or scents)	<input type="checkbox"/> Limited use of hand(s): <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Left</td> <td style="width: 10%; border: none;"></td> <td style="width: 35%; border: none;">Right</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;">Gripping</td> <td style="border: none;"><input type="checkbox"/></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;">Pinching</td> <td style="border: none;"><input type="checkbox"/></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/></td> <td style="border: none;">Other (please specify)</td> <td style="border: none;"><input type="checkbox"/></td> </tr> </table>	Left		Right	<input type="checkbox"/>	Gripping	<input type="checkbox"/>	<input type="checkbox"/>	Pinching	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)	<input type="checkbox"/>
Left		Right														
<input type="checkbox"/>	Gripping	<input type="checkbox"/>														
<input type="checkbox"/>	Pinching	<input type="checkbox"/>														
<input type="checkbox"/>	Other (please specify)	<input type="checkbox"/>														
<input type="checkbox"/> Limited pushing/pulling with: <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm <input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Operating motorized equipment: (e.g. forklift)	<input type="checkbox"/> Potential side effects from medications (please specify). Do not include names of medications.	<input type="checkbox"/> Exposure to vibration: <input type="checkbox"/> Whole body <input type="checkbox"/> Hand/arm													
3. Additional comments on <b>Abilities and Restrictions</b> .																
4. From the date of this assessment, the above will apply for approximately:																
<input type="checkbox"/> 1 - 2 days	<input type="checkbox"/> 3 - 7 days	<input type="checkbox"/> 8 - 14 days	<input type="checkbox"/> 14 + days	5. Have you discussed return to work with the worker? <input type="checkbox"/> Yes <input type="checkbox"/> No												
6. Recommendation for work hours and start date:																
Start Date: MM   DD   YY	<input type="checkbox"/> Regular full-time hours	<input type="checkbox"/> Modified hours Please specify:	<input type="checkbox"/> Graduated hours Please specify:													

## B. Date of Next Appointment

Recommended date of next appointment to review <b>Abilities and Restrictions</b> . MM   DD   YY
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I have provided this completed Functional Abilities form to the worker: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: MM   DD   YY	Health Care Provider's Signature: _____
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Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596  
 Toll Free Fax: 1-866-277-3677 • Email: reportsnwt@wscc.nt.ca  
 or  
 Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8501  
 Toll Free Fax: 1-866-979-8501 • Email: reportsnu@wscc.nu.ca

**wscc.nt.ca or wscc.nu.ca**