

**OCCUPATIONAL INJURY SERVICES
Work Readiness Report**

P.O. BOX 2415
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1-800-661-1993

Please print clearly or type.

WCB Claim Number _____ Personal Health Number _____

Date of Visit: (YYYY/MM/DD) _____ Part of Body Injured: _____ Date of Birth: (YYYY/MM/DD) _____

To be completed by employee

I authorize the health care professional noted below to discuss any work limitations/restrictions with my employer.

Employee Name _____ Signature _____ Date: (YYYY/MM/DD) _____

- Physical Work Capabilities**
- Able – as per usual work duties
 - Unable
 - Limited to – within limitations as defined.

walking	<input type="checkbox"/> able	<input type="checkbox"/> unable	limited to _____	(time)	standing	<input type="checkbox"/> able	<input type="checkbox"/> unable	limited to _____	(time)
squatting /crouching	<input type="checkbox"/> able	<input type="checkbox"/> unable	limited to _____	(time)	climbing	<input type="checkbox"/> able	<input type="checkbox"/> unable	limited to _____	(time)
pushing /pulling	<input type="checkbox"/> able	<input type="checkbox"/> unable	limited to _____	(time)	sitting	<input type="checkbox"/> able	<input type="checkbox"/> unable	limited to _____	(time)
driving	<input type="checkbox"/> able	<input type="checkbox"/> unable	limited to _____	(time)	operating heavy equipment	<input type="checkbox"/> able	<input type="checkbox"/> unable	limited to _____	(time)

grasping	(R)	<input type="checkbox"/> Able	<input type="checkbox"/> unable, limited from: _____	<input type="checkbox"/> prolonged	<input type="checkbox"/> repetitive	<input type="checkbox"/> vibration	specify _____
	(L)	<input type="checkbox"/> Able	<input type="checkbox"/> unable, limited from _____	<input type="checkbox"/> prolonged	<input type="checkbox"/> repetitive	<input type="checkbox"/> vibration	specify _____
reaching	above shoulder (R)	<input type="checkbox"/> able	<input type="checkbox"/> unable	above shoulder (L)	<input type="checkbox"/> able	<input type="checkbox"/> unable	
	below shoulder (R)	<input type="checkbox"/> able	<input type="checkbox"/> unable	below shoulder (L)	<input type="checkbox"/> able	<input type="checkbox"/> unable	

lifting	floor to waist	<input type="checkbox"/> able	<input type="checkbox"/> unable	limited to: _____	maximum of (kg/lb)	<input type="checkbox"/> 4/10	<input type="checkbox"/> 9/20	<input type="checkbox"/> 16/35	<input type="checkbox"/> 23/50	<input type="checkbox"/> 46/100
	waist to shoulder	<input type="checkbox"/> able	<input type="checkbox"/> unable	limited to: _____	maximum of (kg/lb)	<input type="checkbox"/> 4/10	<input type="checkbox"/> 9/20	<input type="checkbox"/> 16/35	<input type="checkbox"/> 23/50	<input type="checkbox"/> 46/100
	above shoulder	<input type="checkbox"/> able	<input type="checkbox"/> unable	limited to: _____	maximum of (kg/lb)	<input type="checkbox"/> 4/10	<input type="checkbox"/> 9/20	<input type="checkbox"/> 16/35	<input type="checkbox"/> 23/50	<input type="checkbox"/> 46/100

environment no restrictions restricted from cold hot wet dry dust noise lighting

hours of work no restrictions limited to _____ hours per day Employer to modify (specify) _____

other (specify) _____

The above named employee was assessed and now deemed:

fit to return to pre-injury work today

fit to return to pre-injury work today with work limitations as above

not fit for any work today, estimated return to work date (YYYY/MM/DD) _____ at pre-injury level with above work limitations

Follow-up visit required? No Yes If yes, Date _____ (YYYY/MM/DD)

I have reviewed the above physical work capabilities with the injured worker.

Attending Health Care Professional _____ Signature _____ Date (YYYY/MM/DD) _____

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.