

Employee Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

**Able to return to full duties without restrictions**

**1. Please indicate Abilities that apply. Include additional details in section 3**

<b>Walking:</b> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 100 metres <input type="checkbox"/> 100 - 200 metres <input type="checkbox"/> Other (please specify)	<b>Standing:</b> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15 - 30 minutes <input type="checkbox"/> Other (please specify)	<b>Sitting</b> <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)	<b>Lifting from floor to waist:</b> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> 15 -20 kilograms
<b>Lifting from waist to shoulder:</b> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> 15 -20 kilograms	<b>Lifting from shoulder and above:</b> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> 15 -20 kilograms	<b>Ladder climbing:</b> <input type="checkbox"/> Full abilities <input type="checkbox"/> 1 - 3 steps <input type="checkbox"/> 4 - 6 steps <input type="checkbox"/> Other (please specify)	<b>Stair climbing:</b> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 steps <input type="checkbox"/> 5 - 10 steps <input type="checkbox"/> Other (please specify)

**2. Please indicate Restrictions 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"/> Environmental exposure to: (e.g. heat, cold, noise or scents)
<input type="checkbox"/> Potential side effects from medications (please specify) Do not include names of medications.	<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"/> Limited use of hand(s): Left <input type="checkbox"/> Gripping <input type="checkbox"/> Pinching <input type="checkbox"/> Other (please specify)	Right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**3. Additional Comments on Abilities and/or Restrictions.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. From the date of this assessment, the above will apply for approximately:**

1 - 2 days       3 - 7 days       8 - 14 days       14 + days

**5. Next date of Review: ( DD/MM/YYYY)**

\_\_\_\_\_

**Doctor's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_