City of Welland
Corporate Services
Human Resources
60 East Main Street, Welland, ON L3B 3X4
Phone: 905-735-1700 Ext. 2271 | **Fax:** 905-734-7608
Email: hr@welland.ca | www.welland.ca

FUNCTIONAL ABILITIES FORM (FAF) – Completed by Medical Professional treating the Employee

The City of Welland is endeavoring to accommodate this employee given his/her current disability and/or restrictions. Please complete the questions and chart below, providing as much information as possible based on your knowledge of the employee's current disability. When answering the questions below keep in mind these activities may occur over a normal eight hour, or twelve hour shift.

Employee Name:	Employee Number:
Position:	Department:
Phone Number:	Supervisor:

1. In general terms, what is the present medical treatment (so appointments can be accommodated)?
_____
_____
_____
_____

2. In your opinion, will the worker be able to fully return to his/her normal job? Yes ❒ No ❒

If yes, how long will this be? Number of Weeks: _____ Number of Months: _____

3. This employee may return to modified work following the restrictions indicated below:

Activity	Continuously	Frequently	Occasionally	Not At All
Walking				
Standing				
Sitting				
Keyboarding				
Stair Climbing				
Ladder Climbing				
Hand Tools				
Power Tools				
Shovels, Rakes, etc.				
Snow Plows				
Tractors				
Trucks				
Other: _____				

Activity	Restrictions
Lifting floor to waist	Less than 10 Kg ❒ Less than 25 Kg ❒ Less than __ Kg Not at all ❒
Lifting waist to shoulder	Less than 10 Kg ❒ Less than 25 Kg ❒ Less than __ Kg Not at all ❒
Above shoulder activity	Yes ❒ Some ❒ None ❒
Other Limitations	
No chemical exposure to:	
No repetitive movement of the:	
No environmental exposure to:	
Restrictions related to medications:	
Exposure to vibration:	

4. Recommendations for work hours:

Full-time (or as per contract) ❒ Modified Hours ❒ _____
Graduated Hours ❒ _____

5. Is a complete recovery expected?

_____

6. Has patient reached Maximum Medical Recovery (MMR)?

_____
_____

7. Estimated duration of restrictions:

Number of Weeks: _____ Number of Months: _____

Restrictions are permanent ❒

8. Other comments:

_____
_____
_____

Name of Physician: _____ Date: _____
(Please Print)

Address: _____
_____

Telephone: _____ Fax: _____

Signature: _____