

City of Welland Corporate Services

Human Resources

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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, wh	nat is the present m	nedical treatment (s	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:					
If yes, how long will this	return to modified	work following the			
If yes, how long will this					
If yes, how long will this 3. This employee may	return to modified	work following the	restrictions indicated	below:	
If yes, how long will this 3. This employee may Activity	return to modified	work following the	restrictions indicated	below:	
If yes, how long will this 3. This employee may Activity Walking	return to modified	work following the	restrictions indicated	below:	
If yes, how long will this 3. This employee may Activity Walking Standing	return to modified	work following the	restrictions indicated	below:	
If yes, how long will this 3. This employee may Activity Walking Standing Sitting	return to modified	work following the	restrictions indicated	below:	
If yes, how long will this 3. This employee may Activity Walking Standing Sitting Keyboarding	return to modified	work following the	restrictions indicated	below:	
If yes, how long will this 3. This employee may Activity Walking Standing Sitting Keyboarding Stair Climbing	return to modified	work following the	restrictions indicated	below:	
If yes, how long will this 3. This employee may Activity Walking Standing Sitting Keyboarding Stair Climbing Ladder Climbing	return to modified	work following the	restrictions indicated	below:	
If yes, how long will this 3. This employee may Activity Walking Standing Sitting Keyboarding Stair Climbing Ladder Climbing Hand Tools	return to modified	work following the	restrictions indicated	below:	
If yes, how long will this 3. This employee may Activity Walking Standing Sitting Keyboarding Stair Climbing Ladder Climbing Hand Tools Power Tools	return to modified	work following the	restrictions indicated	below:	
If yes, how long will this 3. This employee may Activity Walking Standing Sitting Keyboarding Stair Climbing Ladder Climbing Hand Tools Power Tools Shovels, Rakes, etc.	return to modified	work following the	restrictions indicated	below:	
If yes, how long will this 3. This employee may Activity Walking Standing Sitting Keyboarding Stair Climbing Ladder Climbing Hand Tools Power Tools Shovels, Rakes, etc. Snow Plows	return to modified	work following the	restrictions indicated	below:	

Activity	Activity	Destrictions
Less than 10 Kg		
Above shoulder activity Yes Some None Content Limitations No chemical exposure to: No repetitive movement of the: No environmental exposure to: No environmental exposure to: No environmental exposure to: Restrictions related to medications: Exposure to vibration: 4. Recommendations for work hours: Full-time (or as per contract) Modified Hours Maraduated Hours Maraduate		
Other Limitations No chemical exposure to: No repetitive movement of the: No environmental exposure to: No environmental exposure to: Restrictions related to medications: Exposure to vibration: 4. Recommendations for work hours: Full-time (or as per contract)		
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: Please Print Chease Print		TOS LI COMO LI MONO LI
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 Solution Hours Modified Ho	No chemical exposure to:	
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:	No repetitive movement of	
Modified Hours Graduated Hours Graduated Hours Graduated Hours	to:	
4. Recommendations for work hours: Full-time (or as per contract)		
Full-time (or as per contract)	Exposure to vibration:	
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: Same of Physician: Date: (Please Print) Address: Felephone: Fax:		☐ Modified Hours ☐
7. Estimated duration of restrictions: Number of Weeks: Number of Months: Restrictions are permanent □ 8. Other comments: Jame of Physician: Date: (Please Print) ddress: felephone: Fax:	5. Is a complete recovery expe	ected?
Number of Weeks: Number of Months: Restrictions are permanent □ 8. Other comments: lame of Physician: Date: (Please Print) ddress: Fax:	6. Has patient reached Maxim	um Medical Recovery (MMR)?
Restrictions are permanent 8. Other comments: lame of Physician: Date: ddress: Fax: Fax:	7. Estimated duration of restriction	ctions:
8. Other comments: Same of Physician: Date: Comments: Date: Fax: Fax: Date:	Number of Weeks:	Number of Months:
8. Other comments: Solution	Restrictions are permanent \Box	
Date:	·	
Address:	8. Other comments:	
Address:		
Address:		
Address:	lame of Physician:	Date:
	ddress:	ease Print)
Signature:	elephone:	Fax:
	signature:	