Lakehead University

Employee Medical/ Work Limitation Form

Human Resources Department
955 Oliver Road
Thunder Bay, Ontario
P7B5E1
343-8334 or Fax: 3467701

For Employees with Non-Occupational Injuries or Illnesses, Workplace Accommodations Can Be Arranged in Many Cases.

With your input, Lakehead University will review the accommodations required to meet the restrictions, limitations or precautions which you place on this employee's return to work.

Section A: Employee Information (To be completed by Employer)

Our employee, *(NAME)*:

Who works as a (Occupatio n) in the Department

indicates that he/she has a non occupational injury or non occupational illness

To assist us in accomodating him/her on the job, please provide the information requested in section C

Section B: Employee Authorization [To Be Completed by Employee]

I authorize the release of the following information to the University (Signature)

Section -C Restrictions, Limitations and Precautions (To be completed by the Health Care Provider)

Nature of Injury or Illness:	
Option 1:	Employee may return to Regular Duties at Once.
Option 2:	Employee may return to Regular Duties at Once, provided that the following restrictions, limitations and/or precautions are in place:

Lifting	Carrying	Pushing/Pulling	Standing	Non	Max.hour(s)
None with R arm	None with R arm	None with R arm	Sitting	Non	Max.hour(s)
None with L arm	None with L arm	None with L arm	Walking	Non	Max.hour(s)
Maxlb.	Max lb.	Max._lb.	Climbing Stairs	Non	Max._steps(s)
Max hour(s)	Max._hour(s)	Max.hour(s)	Ladders	Non	Max._steps(s)

Comments and additional precautions to be followed

Accomodations will be required for Days ; for weeks , or Permanently

At the end of modified work period, this employee:

May return to regular duties or

Must return for reassessment

☐ Option 3: Employee is totally disabled and is unable to do his/her own job with or without accomodation

This employee must remain off work for:

DAYS, OR WEEKS, AND

At the end of that period, I anticipate that he/she:

May return to regular duties

May return to modified duties

Name and Address of the Health Care Provider

SIGNATURE:	DATE:

EMPLOYEE: THIS FORM MUST BE COMPLETED AND RETURNED TO THE HUMAN RESOURCES DEPARTMENT, LAKEHEAD UNIVERSITY.