Lakehead University: Employee Medical/Work Limitation

Human Resources Department
955 Oliver Road
Thunder Bay, Ontario
P7B 5E1
343-8334 or FAX 346-7701

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 *[OCCUPATION]* ________________________ in the ___________________________________ Department,
indicates that he/she has ☐ a non-occupational injury *OR* ☐ a non-occupational illness.

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 & Precautions [To Be Completed by Health Care

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	None	Max. ____ hour(s)
None with R arm	None with R arm	None with R arm	Sitting	None	Max. ____ hour(s)
None with L arm	None with L arm	None with L arm	Walking	None	Max. ____ hour(s)
Max. ______ lb.	Max. ______ lb.	Max. ______ lb.	Climbing Stairs	None	Max. ____ steps(s)
Max. ____ hour(s)	Max. ____ hour(s)	Max. ____ hour(s)	Ladders	None	Max. ____ steps(s)

Comments &/or Additional Precautions to be Followed:

____

____

____

____

Accommodations will be required: for ____ DAYS; for ____ Weeks or Permanently ☐

At the end of the modified work period, this employee:

- ☐ **May return to regular duties OR ☐ Must return for a re-assessment.**

☐ ***Option 3:*** **Employee is Totally Disabled and is unable to do his/her own job with or without accommodation.**

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, OR ☐ may return to Modified Duties.

NAME & ADDRESS OF HEALTH CARE PROVIDER:

SIGNATURE:	DATE:

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