Office of Human Resources
(807) 343-8010 ext 8671
e: trmoore@lakeheadu.ca

Dear Health Care Professional,

You are being asked to complete the following Medical Documentation Form by an employee who is requesting accommodations due to a medical limitation/restriction, to document an employee's inability to work due to limitations or as a medical clearance to return to work after a prolonged absence. We seek the following information:

1. Confirmation and verification that the employee has a permanent or temporary disability/medical condition
2. Confirmation of functional limitation the employee experiences directly related to their disability/medical condition and how this pertains to essential job duties
3. Whether this employee can safely perform duties which may be safety sensitive, risk sensitive or decision critical
4. The duration of the condition and the duration need for accommodation
5. If specific accommodations are suggested, include which are flexible can be adjusted by the employee without your professional re-evaluation

Important: A current Job Demands Report (JDR) is provided as part of this package. Please review the JDR and use it to guide your assessment and responses regarding the employee's ability to meet the functional demands of their position.

Note: Disclosure of diagnosis is not required. The completed form will be treated as strictly confidential and shared only with the Office of Human Resources.

Please note interim accommodations can be provided for employees who are in the process of being assessed for a mental health disability.

Lakehead University is committed to supporting employees through individualized, medically-supported accommodation plans in accordance with the Ontario Human Rights Code and Lakehead University's Accommodation for Employees with Disabilities Procedure. Lakehead University is an in-person educational institution and although most employees did work remotely during the pandemic during Provincial mandates, the majority of our positions provide essential in-person support for our student community. Requests for remote work must be accompanied by a direct link between the employee's medical limitation and the inability to accommodate in-person.

The information you provide will be used by the Office of Human Resources to design an individualized accommodation plan. This plan helps to ensure the employee has an equitable opportunity to fulfill the essential occupational requirements at Lakehead University.

Any information provided on this form will be kept strictly confidential and will not be shared with anyone outside of the Office of Human Resources without the employee's written consent.

If you have any questions or concerns, please contact our office:
Thunder Bay and Orillia Campus
Phone: (807) 343-8010 ext. 8671

Email: trmoore@lakeheadu.ca

Functional Accommodation/Abilities Form For a Timely Return To Work

SECTION A: Completed by the Employee

Employee Name	Date of Assessment:
Job Title	DOB

Authorization: I authorize my health professional involved with my treatment to provide my employer with this form when completed, containing any medical limitations/restrictions related to my ability to return to work/accommodation request and perform my assigned duties. I understand that Functional Accommodation/Abilities Form conducted without a current Job Demands Report may necessitate a subsequent updated assessment to meet the requirements of the Accommodation Policy. I understand that my employer may require clarification related to my accommodation request and may contact my physician directly for this information.

Employee Signature: Date:

SECTION B: (to be completed by a licensed medical practitioner)

Complete all relevant sections. Missing information will require the employer to follow-up. Please reference any job description, physical demands analysis or job summary that have been provided in determining any restrictions.

□ Normal Functional Abilities - fit for regular duties and hours. **Skip to Section E**

□ Reduced Functional Abilities - fit for work with the limitations/restrictions. Employee has a medically verified condition resulting in reduced functional abilities. **Complete all Sections**

□ Unfit to Work. **Complete all Sections** and **indicate current prognosis** to return to work (choose one)
□ 1 Month □ 3 Months □ 6 Months □ 9 Months □ 1 year □ > 1 year

Is the employee under your active care?	□ Yes	□ No, please indicate other treatment providers:
Date of Next Medical Review	□ Yes	□ No, please explain:
Is there a treatment plan in place?	□ Yes	□ No, please explain:
Is the employee compliant with the Treatment?	□ Yes	□ No, please explain:
Was a formal assessment, testing or measurement completed to determine functional abilities?	□ Yes	□ No, please explain:
Employee will return to work: □ Remote* □ In person * may not be possible for all positions	Date of Remote Return (if applicable):	
	Date of Return to in-person:	

SECTION C: (to be completed by a licensed medical practitioner)

PHYSICAL LIMITATIONS □ This employee does not have Physical Limitations (skip to section D)			
Lifting floor to waist: □ Full abilities □ 5-10 kg □ Up to 5 kg	**Lifting waist to shoulder:** □ Full abilities □ 5-10 kg □ Up to 5 kg	**Lifting at or above shoulder:** □ Full abilities □ 5-10 kg □ Up to 5 kg	**Sitting/Standing/Walking:** Sit Stand Walk Full ability □ □ □ <60 min □ □ □ ~15-30 min □ □ □
Hand Function □ Full abilities both hands **Dominance:** □ Left or □ Right □ Avoid use □ L □ R	**Pushing/Pulling:** □ Full abilities □ Occasional **Details:**	**Reaching:** □ Full abilities □ No over the shoulder □ No overhead	**Bending/Crouching/ Kneeling/Climbing:** □ Full abilities □ Occasional **Details:**

SECTION D: (to be completed by a licensed medical practitioner, include specific information on workplace triggers or impacts to essential duties, additional space provided on final page)

Supervision Needs: □ None □ Requires additional supervision (details required) Details:	**Supervision of Others:** □ Able to supervise others □ Not able to supervise others (details required) Details:	**Tolerance to Deadlines:** □ No limitations □ Time Management support recommended (details required) Details:
Performance of Multiple Tasks: □ No limitations □ Reduced ability to multi-task (details required) Details:	**Concentration and Tolerance for External Stimulus:** □ Fully capable □ Reduced ability (details required) Details:	**Ability to work with others:** □ Can work with others cooperatively □ Reduced ability (details required) Details:
Attention to Detail: □ No limitations □ Cognitive fatigue or processing limitations (details required) Details:	**Ability to cope with confrontational situations:** □ No limitations □ Reduced ability (details required) Details:	**Adaptation to changes:** □ No limitations □ Reduced ability (details required) Details:
Decision Making/ Judgement: □ No limitations □ Reduced ability (details required) Details:	**Learning and Memory:** □ No limitations □ Reduced ability (details required) Details:	**Communication:** □ No limitations □ Reduced ability (details required) Details:
Ability to attend workplace: □ Able to attend workplace OR □ Reduced ability (specific barriers to attending workplace must be provided) Barriers:		

Other Limitations/Restrictions not listed above: (provide details and explain how this affects employee's abilities to perform essential duties of their job):

Is the duration of these limitations/restrictions permanent or temporary? If temporary, please indicate the duration expected: □ Permanent □ Temporary Duration of need for accommodation:
Please indicate whether the employee's current condition or limitations may impact their safe performance in the following role types: • **Safety-Sensitive Position:** (e.g., security officer, laboratory worker, professional driver — where lapses in attention, memory, or judgment could result in harm to self or others) ☐ No concerns ☐ Yes — please explain: _____ • **Risk-Sensitive Position:** (e.g., roles that direct safety-sensitive staff or make operational decisions in potentially dangerous environments) ☐ No concerns ☐ Yes — please explain: _____ • **Decision-Critical Role:** (e.g., positions where impaired decision-making could result in serious liability, reputational harm, or economic loss to the institution) ☐ No concerns
Other details to be considered in the accommodations plan, if applicable, please include symptom triggers that require management in the workplace:

SECTION E:
By affixing my signature below, I certify that I am a licensed medical practitioner. I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

Name (please print):	Health Profession (please print):
Address:	Phone: Fax:
Job Demands Report was provided and reviewed in the context of the above noted restrictions/limitations. □ Yes □ No	
Signature:	Date:

Once completed: please email to trmoore@lakeheadu.ca.