

Stay at or Return to Work Form 111

Last revised: July 2021
Last reviewed: October 2018
Next review: October 2019

The purpose of this form is to provide information to assist the employee to stay at work if possible, or plan for the employee's safe return to work at the earliest possible date.

Section I: Personal Information (To be completed by the Manager/Supervisor)

Employee's Name

Employee's Work Location

Employee's Occupation

Work-related injury or illness? Yes No Date of injury or illness or date became aware: _____

* Supervisor to complete WCB E1 Form and Incident Reporting & Investigation Form 101 if this illness/injury is workplace related.

Brief Description of Employee's Regular Core Duties (Attach Job Demands as appropriate):

Employee to return this form (completed both sides) to Manager/Supervisor within ___ days.

Printed Name of Manager/Supervisor completing this form. _____

Section II: Employment Responsibilities (To be completed by Manager/Supervisor and signed by employee)

- 1) Take this form to your Licensed Health Care Practitioner regarding this injury/illness/surgery so he/she can complete Section III (reverse side) and return it to you during that visit.
- 2) You are to return this form (completed both sides) to your Manager/Supervisor within _____ days (as above)
- 3) Alternate contact information: (If person to receive the form different from Manager/Supervisor e.g. Ministry Contact, Human Resources, etc.). Manager/Supervisor to fill in.

Name and Title: _____

Address: _____

Email and Phone: _____

Fax: _____

- 4) If this is a workplace illness/injury, you will also complete a WCB W1 Form and assist in the completion of an Incident Reporting and Investigation Form 101.
- 5) I acknowledge my responsibilities and CONSENT my Licensed Health Care Practitioner to completing Section III of this form.

Employee Signature

Date

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Section III: To be completed by the licensed health care practitioner

Date of Examination

Do your findings restrict this employee from attending work and any and all duties? Yes No

If yes, please indicate **ALL** the restrictions /limitations. Check **ALL** restrictions that apply and specify details in the space provided below.

- Lifting: <10lbs <20lbs <50lbs Avoid repetitive lifting
 Avoid overhead lifting Lifting as tolerated No lifting
- Bending /twisting: No bending /twisting Avoid repetitive bending/twisting
- Standing Climbing (stairs /ladder) Walking Kneeling / Crouching
- Keyboarding Pushing/Pulling Sitting
- Limitations due to environment Heat Cold Dust Fumes
- Operating Equipment Driving
- Cognitive limitations Memory Concentration Decision making Multi-tasking
- Other _____

Anticipated duration of restriction(s) _____ days. If more than one restriction, indicate the duration of each:

Date of re-evaluation/next visit with you (if necessary): _____

Please provide further details or additional information that may restrict the employee's plan to safely stay at or return to the workplace (if applicable): **Do not include diagnosis**

Signature of Licensed Health Care Practitioner

Licensed Health Care Providers Stamp