Lakehead University:
Employee Medical/Work Limitation Form

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.
To assist us in accommodating 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 & Precautions [To Be Completed by 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**	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.