Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

MODIFIED DUTY FORM

TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY if there has been a change in patient's abilities. WRHA will pay up to **$25.00** for the **COMPLETED** form. Completed forms can be faxed to **WRHA OESH CONFIDENTIAL FAX LINE 204-477-3449**

Employee Name:	**Position:**	**Site:**
Authorization of Employee: *I authorize the release of this information to the Winnipeg Regional Health Authority Occupational and Environmental Safety & Health Department.* _____ _____ *Employee Signature* *Date*	**General Nature of illness/injury:** *(specific diagnosis should not be included)*	

RETURN TO WORK:

Start Date: _____/_____/_____
dd mm yyyy

☐ **Full Functional Abilities** ☐ **Reduced Functional Abilities**

Estimated Duration: _____

Recommended Gradual Hours ***(if applicable)***

Graduated	Hours / Day	Days / Week
week 1		
week 2		
week 3		
week 4		
week 5		

FUNCTIONAL ABILITIES

(Please be specific and check all that apply)

KEY

***FREQUENCY**
N – Never
O – Occasional (up to 33% of the day)
F – Frequent (between 34-66% of the day)
C – Constant (between 67-100% of the day)

Mobility/Posture	N	O	F	C	Mobility/Posture	N	O	F	C
Sitting	☐	☐	☐	☐	Neck ROM *(specify)*	☐	☐	☐	☐
Standing	☐	☐	☐	☐	Shoulder/Reaching ☐ R ☐ L At Shoulder Level	☐	☐	☐	☐
Walking	☐	☐	☐	☐	Below Shoulder Level	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	Above Shoulder Level	☐	☐	☐	☐
Deep Squat/Crouch	☐	☐	☐	☐	Low Back Bending/Twisting	☐	☐	☐	☐
Stairs/Climbing	☐	☐	☐	☐	Hand Dexterity/Fine Motor	☐	☐	☐	☐
Other:	☐	☐	☐	☐	Gripping ☐ R ☐ L ☐ Power ☐ Pinch	☐	☐	☐	☐

Strength / Exertion *(check all that apply)*	**0 - 10lbs**				**10 – 20lbs**				**20 – 50lbs**			
	N	**O**	**F**	**C**	**N**	**O**	**F**	**C**	**N**	**O**	**F**	**C**
LIFTING: Floor to Waist	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LIFTING: Waist to Shoulder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LIFTING: Above Shoulder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
CARRYING	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
PUSH/PULL FORCE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Additional recommendations regarding functional abilities:

Healthcare Provider Information:

Name:	**Clinic Information:**
Signature:	**Date:**