Sample Release of information form:

I authorize my treating medical practitioner to provide the following information to the Human Resource person responsible for my file information:

- verification that I am experiencing an injury or medical condition that currently prevents me from performing some or all of the duties of my job.
- whether returning to work is possible, and if so when can I return to work.
- what, if any, accommodations should be made to my job duties or in the workplace to enable me to safely return to work.

To be clear, you are not required to provide a diagnosis; the release of any medical information is limited to answering the attached medical questionnaire, as well as clarifying the provided answers.

I understand that I will be provided with a copy of this information.

____________________	__________
Name	Date

Sample medical ability to work form

The purpose of this form is to provide the patient with the necessary information that they need to give to their employer to help the employer make decisions about accommodating the patient, providing disability leave, or assessing if the patient can return to work.

When completing this form, disclose only information necessary to meet the purpose of the form. Typically, it is not necessary to provide a diagnosis or treatment information.

Physicians name and address:

I saw __________________ (patient's name) on______________ (date)

Date of injury or illness, if applicable ______________

This patient is medically able to work with limitations or restrictions as of ____________________ (date).

Restrictions or limitations (see page 2 for details)

In my opinion, these restrictions or limitations are:

☐ Temporary:	☐ ___ days	☐ 4 to 6 weeks
	☐ less than 2 weeks	☐ 6 weeks to 3 months
	☐ 2 to 4 weeks	☐ more than 3 months

☐ Permanent: Date of next appointment _________________

My opinion is based on the factors indicated below:

☐ Information provided by the patient

☐ My examination of the patient and my assessment of the findings and health information

I have provided this form to the patient named above

_____________________________ _______________

Physician's signature Date

Specific Functional Restrictions and/or Limitations

Patient's name ______________________________

DEFINITIONS:
- **Restriction**: This patient is advised not to perform this activity in any capacity
- **Limitation**: This patient is able to perform the activity in a reduced capacity. For example, the patient is not able to perform the job with the usual speed, strength or number of repetitions, or for the usual duration

Check ☑ only those items that apply in section A and provide details in section B

SECTION A:

PHYSICAL	**Restriction**	**Limitation**	**MENTAL**	**Restriction**	**Limit-ation**
sitting			Thinking/ reasoning		
standing			concentration		
walking			memory		
lifting			critical decision-making		
carrying			interpersonal contact		
Pushing/ pulling			alertness		
climbing stairs			other (specify in section b)		
climbing ladders			**ENVIRONMENTAL**		
climbing scaffolding			exposure to heat/ cold		
crouching			exposure to dust/fumes/odor		
crawling			exposure to chemicals		
kneeling			food handling		

Bending/ Twisting/ turning			other (specify in section b)		
repetitive activity			**OTHER**		
sustained postures			shift/attendance duration		
gripping			consecutive shift attendance		
reaching			shift work		
Fine dexterity			overtime		
balance			operating vehicle		
Vision/ hearing/ speech			operating equipment		
other (specify in section b)			working heights		
			other (specify in section b)		

Does the patient require medical aids (e.g. splint, brace) or personal protective equipment (e.g. gloves, mask)?

☐ No ☐ yes (specify in section B)

SECTION B

Please provide necessary details about any restrictions or limitations you have identified. It is not necessary to provide a diagnosis or treatment information.

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I have provided this form to the patient named above.

________________________ ____________________

Physician’s signature date