Completing the

Functional Abilities Form (FAF)

for Planning Early and Safe Return to Work

WORKER/EMPLOYER

SECTION A- WORKER/EMPLOYER INFORMATION

The worker and the employer complete this section. Proper identification, including names, addresses and phone numbers will help the WSIB process the information quickly and efficiently.

SECTION A.1. TYPE OF JOB AT TIME OF ACCIDENT

In order to plan return to work, all parties need to understand exactly what the worker was doing at the time of the injury or illness. The employer should include a detailed job description and, if available, a Physical Demands Analysis (PDA) for the worker's job. If there is no PDA available for the job, the employer may wish to use the WSIB's Physical Demands Information Form (PDIF - available on the WSIB website under "Employer Forms").

Please ensure that all areas of injury/illness are noted in this section of the FAF.

1. Type of job at time of accident (where available, please attach description of job activities)	Area(s) of injury(ies)/illness(es)

SECTION A.2. DISCUSSION OF RETURN TO WORK BETWEEN THE EMPLOYER AND WORKER

Return to work is a shared responsibility, primarily between the worker and employer. In this section of the form, the employer should indicate whether return to work discussions have taken place with the worker. If not, the date on which a return to work discussion will take place should be noted. By the employer and worker discussing RTW, the process of communication and cooperation that is essential in getting a mutually agreeable RTW plan begins.

2. Have the worker and the employer discussed Return To Work ☐ yes ☐ no	If no, will be discussed on dd mm yyyy

A.3. NAME OF EMPLOYER CONTACT

The name and position of the employer contact is important for communication between the worker, employer, the WSIB and the health professional. Please indicate the person who is the central contact in coordinating the Return to Work plan at the workplace.

3. Employer contact name	Position

SECTION B-SIGNATURE OF THE WORKER

The worker is obligated to provide consent for the release of the functional abilities information to the employer. The worker should sign and date the form. This ensures that the worker consents to and understands the reason why the FAF information will be shared with the employer and the WSIB. It is important for the employer to explain to the worker that the shared information pertains only to his/her functional abilities as outlined on the form. No medical information is to appear on the form. It is helpful for clarity of information if the employer discusses RTW and ensures that the worker signs the FAF before it goes to the health care profesional.

B. Worker's Signature

By signing below, I am authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board (WSIB) with information about my functional abilities on the WSIB's "Functional Abilities for Planning Early and Safe Return to Work" form.

Signature	Date dd mm yyyy

WSIB ONTARIO CSPAAT

SECTION C

This section requires information from the health professional for billing purposes. It should be mailed or faxed to the WSIB at the address/fax number listed on the front of the FAF. The completion of this form does not replace clinical reporting requirements to the WSIB. For privacy reasons, diagnostic information must never be provided on this form. The information in the shaded area of the billing section should also remain confidential to protect the health care provider's privacy.

C. Health Professional's Billing Information
For billing purposes fax or mail pages 2 and 3 to the WSIB.

INFORMATION IN SHADED AREAS SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER

Health Professional's Designation

☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class) ☐ Other

Are you registered with the WSIB?
☐ Yes Please enter the nine digit **WSIB Provider ID.** in the box provided ▶
☐ No Please call **1 - 800-569-7919** to register

WSIB Provider ID.

Health Professional's Name (please print)

Service Code **901**

Address (No. Street, Apt.)

Your Invoice Number

City/Town | Province | Postal Code

Fax ( )

I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation to the WSIB.

Health Professional's Signature | Telephone ( ) | Date dd mm yyyy

SECTION D & E

These sections of the form are where the health professional identifies the worker's overall functional abilities. This information is critical for the employer and worker to be able to plan an early, safe, and successful RTW. Please complete this section in as much detail as possible so that the worker and employer can identify suitable work that can contribute to the worker's active recovery in the workplace. With detailed information about the worker's ability to lift, walk, stand, etc., the employer can identify possible job accommodations as part of a phased return to work while the worker continues to recover from the workplace injury/illness.

If the worker is physically unable to return to work and requires additional time to heal, proceed to Section F and provide the date at which the worker's condition will be re-assessed.

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment dd mm yyyy

2. Please check one:

- ☐ Patient is capable of returning to work with **no restrictions.**
- ☐ Patient is capable of returning to work **with restrictions.** Complete sections **E and F.**
- ☐ Patient is physically unable to return to work at this time. Complete section **F.**

E. Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Lifting from waist to shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

Stair climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

Ladder climbing:
- ☐ Full abilities
- ☐ 1 - 3 steps
- ☐ 4 - 6 steps
- ☐ Other (please specify)

Travel to work:
- Ability to use public transit: ☐ Yes ☐ No
- Ability to drive a car: ☐ Yes ☐ No

2. Please indicate **Restrictions** that apply. Include additional details in section 3

- ☐ Bending/twisting repetitive movement of (please specify)
- ☐ Work at or above shoulder activity:
- ☐ Chemical exposure to:
- ☐ Environmental exposure to: (e.g. heat, cold, noise or scents)
- ☐ Limited use of hand(s): Left / Right — ☐ Gripping ☐ Pinching ☐ Other (please specify)
- ☐ Limited pushing/pulling with:
  - ☐ Left arm
  - ☐ Right arm
  - ☐ Other (please specify)
- ☐ Operating motorized equipment: (e.g. forklift)
- ☐ Potential side effects from medications (please specify) Do not include names of medications.
- ☐ Exposure to vibration:
  - ☐ Whole body
  - ☐ Hand/Arm

3. Additional Comments on **Abilities and/or Restrictions**.

4. From the date of this assessment, the above will apply for approximately:
☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Have you discussed return to work with your patient? ☐ Yes ☐ No

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours Start Date dd mm yyyy

SECTION E5

The health professional has an important role in the return to work process and can assist the worker in feeling comfortable about the importance and value of early and safe return to regular life activities, including returning to work.

5. Have you discussed return to work with your patient? ☐ Yes ☐ No

SECTION E6

Please indicate here what hours and start date are recommended for the RTW Plan.

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours Start Date dd mm yyyy

SECTION F

Please indicate date of next appointment for follow-up. This will help the employer in the process of the RTW planning and evaluation of success.

F. Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions**. ▶ dd mm yyyy

NOTES:

WSIB ONTARIO
Workplace Safety & Insurance Board
CSPAAT
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail
www.wsib.on.ca

For additional information or assistance, please contact your adjudicator or refer to **www.wsib.on.ca**.