WSCC Workers' Safety & Compensation Commission | ᐃᖅᑲᓇᐃᔭᖅᑎᓄᑦ ᐊᑦᑕᓇᖅᑐᓂᒃ ᐊᒻᒪ ᓇᓪᓕᐅᒃᑯᒫᓂᒃ ᖃᐅᔨᓴᖅᑎᑦ

First Medical Report

Complete this form and return it, <u>with your invoice</u>, to the address on the reverse.

Worker Information

Last Name	First Name	
Mailing Address (include postal code)	Community	Telephone (include area code)
Employer	Worker's Occupation	
Date of Injury MM / DD / YY	Date of Birth MM / DD / YY	Gender ☐ M ☐ F

Health Care Provider Information

Name of Health Care Provider (please print)	Address (include postal code)
Telephone (include area code)	
Date of Exam MM / DD / YY — Time	

Subjective

Worker's description of injury.
Describe complaints.

Objective

Describe **objective** findings, including any diagnostic results.	
Diagnosis:	
Treatment plan and medication:	
Any follow-up plan? ☐ Yes ☐ No	Date of follow-up visit MM / DD / YY
Any factors that may complicate recovery? *(e.g., a pre-existing condition)* ☐ Yes ☐ No *If yes, please explain, attaching details if needed.*	
Is worker fit to return to work with no restrictions? ☐ Yes ☐ No **If no, complete Functional Abilities on the reverse side.**	

The WSCC may use this information for the administration of the *Workers' Compensation Acts*, the *Safety Acts*, and/or the *Mine Health and Safety Acts*, and their associated *Regulations*.

I hereby certify the above is a correct statement of services personally rendered by myself.

Health Care Provider's Signature ______________________________ Date ____________________

CS003 0713

Functional Abilities

Worker's Last Name	First Name	Claim Number

Identify the worker's overall abilities and restrictions.

A. Abilities and 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)

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:
- ☐ Environment 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 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 the worker?
☐ Yes ☐ No

6. Recommendation for work hours and start date:
☐ Regular full-time hours
☐ Modified hours — Please specify:
☐ Graduated hours — Please specify:
Start Date: MM | DD | YY

B. Date of Next Appointment

Recommended date of next appointment to review **Abilities and Restrictions.** MM | DD | YY

I have provided this completed Functional Abilities form to the worker:
☐ Yes ☐ No Date: MM | DD | YY

Health Care Provider's Signature: _____

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wscc.nt.ca or **wscc.nu.ca**

Ce formulaire est disponible en français
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