WSCC Workers' Safety & Compensation Commission | ᐃᖃᓇᐃᔭᖅᑎᓄᑦ ᐊᑦᑕᕐᕆᓂᒃ ᐊᒻᒪ ᓇᓪᓕᐅᒃᑯᒥᓂᒃ ᖃᐅᔨᓴᖅᑏᑦ

Medical Progress Report

Complete this form and return it to the address on the last page.

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 YYYY	Date of Birth MM DD YYYY

Health Care Provider Information

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

Subjective/Objective

Any change in diagnosis? ☐ Yes (please explain) ☐ No
Describe subjective complaints.
Describe objective findings and lab or x-ray results.
Treatment plan and medication:

Investigation

Refer to Specialist? ☐ Yes ☐ No	If yes, will you arrange this? ☐ Yes ☐ No	Type of Specialist
Date of follow-up visit MM DD YYYY	***If worker's abilities have significantly changed, complete Functional Abilities on the reverse side, and provide a copy to the worker.***	Refer to WSCC Medical Advisor? ☐ Yes ☐ No For ______
Factors complicating recovery ☐ Yes (please explain) ☐ No		

The WSCC may use this information for the administration of legislation under our authority, including the *Workers' Compensation Acts*, the *Safety Acts*, and/or the *Mine Health and Safety Acts*, and their associated *Regulations*, and to contact you in relation to the requirements under the relevant legislation.

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

Health Care Provider's Signature ______ **Please print form to sign.** Date MM DD YYYY

CS004 0824

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 | YYYY

B. Date of Next Appointment

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

I have provided this completed Functional Abilities form to the worker:

☐ Yes ☐ No Date: ____ ____ ____ (MM DD YYYY)

Health Care Provider's Signature: **Please print form to sign.**

Yellowknife: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: 867-920-3888 • Toll Free: 1-800-661-0792 • Fax: 867-873-4596
Toll Free Fax: 1-866-277-3677 • Email: reportsnwt@wscc.nt.ca
or
Iqaluit: 2A-630 Queen Elizabeth Way, Iqaluit, NU X0A 3H0 • Telephone: 867-979-8500 • Toll Free: 1-877-404-4407 • Fax: 867-979-8501
Toll Free Fax: 1-866-979-8501 • Email: reportsnu@wscc.nu.ca

wscc.nt.ca • wscc.nu.ca

Ce formulaire est disponible en français