WSCC Workers' Safety & Compensation Commission

Physiotherapy/ Occupational Therapy

Functional Abilities Report – Form C

Date of Initial Assessment	YYYY	MM	DD

WSCC Claim Number

Worker Information

Last Name	First Name	Middle Initial	Area and Type of Injury
Employer Name			
Employer Contact Name		Phone	

Health Care Provider Information

Provider Name		Practitioner ID Number
Practitioner Name	Phone	Fax

Physical Abilities Assessment

Weights Pounds ☐ Kilograms ☐	Period 1			Period 2			Period 3			Period 4			**Pre-injury Job Demands**		
Ability Test Date	YYYY	MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	MM	DD	Weights reported by:		
F = Frequent (66%) **O** = Occasional (33%)	**F**		**O**	**F**		**O**	**F**		**O**	**F**		**O**	Worker	Employer	Other
Lifting															
Above Shoulder															
Horizontal															
Floor/Waist															
Carrying															
Right Hand															
Left Hand															
Both Hands															
Pushing															
Pulling															

Tolerance									Time reported by:		
R = Reported **O** = Observed	**R**	**O**	**R**	**O**	**R**	**O**	**R**	**O**	Worker	Employer	Other
Standing (minutes)											
Sitting (minutes)											
Walking (distance)											

Grip Strength **R** = Right **L** = Left	**R** ☐	**L** ☐	**R** ☐	**L** ☐	**R** ☐	**L** ☐	**R** ☐	**L** ☐

Physical Abilities Assessment (continued)

Other Essential/Critical Job Tasks												
	Period 1			**Period 2**			**Period 3**			**Period 4**		
	YYYY	MM	DD	YYYY	MM	DD	YYYY	MM	DD	YYYY	MM	DD
Work Capability **P** = Pre-injury Job Duties **M** = Modified Duties	**P** ☐ **M** ☐			**P** ☐ **M** ☐			**P** ☐ **M** ☐			**P** ☐ **M** ☐		
Overall Functional Progress **I** = Improving **N** = No Change **D** = Declining	**I** ☐ **N** ☐ **D** ☐			**I** ☐ **N** ☐ **D** ☐			**I** ☐ **N** ☐ **D** ☐			**I** ☐ **N** ☐ **D** ☐		
Tester's Initials												
Comments												

Return to Work/Stay at Work Plan (if **M** duties selected above)

Period 1	
Period 2	
Period 3	
Period 4	

Final Return to Work Outcome (completed on discharge)

☐ No time lost	☐ Pre-injury	Date	YYYY	MM	DD
☐ Did not return (state reason)	☐ Suitable	Date	YYYY	MM	DD
Discharge Date	YYYY	MM	DD		

Copied to Physician, Employer, and WSCC

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. It is your responsibility when providing an email address to ensure reasonable safeguards are in place to protect the confidentiality and security of your personal information within your email account.

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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
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Ce formulaire est disponible en français