wsib cspaat ONTARIO

Claim Number (If known)

8 Health Professional's Report (Form 8)

Return To Work Information

Once completed, please ensure that a copy of this page only is provided to the worker.

Last Name	First Name	Init.	Birth Date (dd mm yyyy)
KIOKE	MADELAINE		09 11 1950

Area(s) of Injury(ies)/Illness(es): L hand

Date of Incident (dd mm yyyy): 16 01 2020

F. Return To Work Information - Must be completed by a Health Professional

When work injury/illness occurs, focus on return to usual activity including return to safe and appropriate work is best practice. Most workers who experience soft tissue injury are able to remain at work.

1. Have you discussed return to work with your patient? ☒ yes ☐ no

2. ☒ **This worker can resume Regular duties. Start date** (dd mm yyyy) 21 01 2020 **If graduated hours required please specify** _____

☐ **This worker can begin Modified duties. Start date** (dd mm yyyy) _____ **If graduated hours required please specify** _____

☐ **This worker is not able to work because of the workplace injury/illness.**

Please provide explanation _____

3. Please indicate the worker's status and functional abilities in relation to the workplace injury and diagnosis.

A. Full Functional Abilities ☒

B. Worker Functional Abilities

	Able to	Not Able to		Able to	Not Able to		Able to	Not Able to
Bend/Twist	☐	☐	Operate Heavy Equipment	☐	☐	Stand	☐	☐
Climb	☐	☐	Operate a Motor Vehicle	☐	☐	Use of Public Transportation	☐	☐
Kneel	☐	☐	Push/Pull	☐	☐	Use of Upper Extremities	☐	☐
Lift	☐	☐	Sit	☐	☐	Walk	☐	☐

C. Other Limitations: eg. Environmental Conditions, Medication, Use of Protective Equipment.

Please describe: _____

4. From the date of this assessment, the above limitations will apply for approximately:

☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Follow-up Appointment

☐ None required ☒ As Needed Date of next appointment (dd mm yyyy) _____

Health Professional's Name (Please print)	Address	
[illegible]	TDH, 700 Ross Ave East, Timmin, ON, P4N 8P2	
Health Professional's Signature	**Telephone**	**Service Date** (dd mm yyyy)
[signature]	705-267-6340	20 01 2020

G. Worker's Signature

By signing below I am authorizing the above noted health professional, who is treating me, to provide my employer with a copy of this page outlining my functional abilities. I understand a copy will be sent to the Workplace Safety and Insurance Board (WSIB) by my health professional.

Signature	Date (dd mm yyyy)
Madelaine Kioke	20 01 2020

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