Return to Work Restrictions Form

Notes to physician

Bourgault Industries Ltd. wishes to ensure the prompt and safe rehabilitation and return to work of our team members. We are committed to providing suitable and meaningful modified duties for team members unable to perform their regular duties as a result of injury or illness. We welcome the support and interest of you, the health care professional, in meeting our commitment and assisting us in this effort.

Mental Health: Avoidance of anxious situations is thought to increase the likelihood that one will avoid future anxiety-inducing situations. For that reason Bourgault Industries focus is on determining work that facilitates the employee remaining in the workplace. When time away from work is required for medical reasons it is most helpful when this includes a clear treatment plan that will realistically return the employee back to work at a functional level.

Name of Health Care Professional (please print): _____

Signature of Health Care Professional: _____

I saw _____ on _____.
(Print patient's name) (Date)

Date of injury or illness _____
(Date)

This patient is medically able to work with limitations or restrictions as of _____
(Date)

Restrictions or limitations (see page 2 for details)

In my opinion, these restrictions or limitations may affect activity for:

☐ _____ days ☐ _____ weeks ☐ Greater than _____ weeks

Date of next appointment is (indicate **n/a** if not applicable) _____.
(Date)

My opinion is based on the factors indicated below:

☐ Information provided by the patient
☐ My examination of the patient and my assessment of the finding and health information

Should you wish to discuss the Return to Work Restrictions Form, please contact Bourgault Human Resources at 701-852-8800

Address: _____ Telephone: _____
Note: a fee of $15.00 will be provided for completion of this form, please invoice to the attention of the Human Resources Dept.

Please return with disabled Team Member or e-mail/fax to:

Bourgault Industries Ltd.
PO Box 1118, 3915 N. Broadway
Minot, ND 58702
Tel: (701) 852-8800 Fax: (701) 852-8844
E-mail: bnelson@bourgault.com
Attention: Human Resources Department

Specific functional restrictions and/or limitations

Patient's name _____

Check ☑ only those items that apply in Section A, and provide details in Sections B.

Definition
Restriction: This patient is advised not to perform this activity in any capacity.
Limitation: This patient is able to perform the activity in a reduced capacity. For example, this patient is not able to perform the job with the usual speed, strength or number of repetitions, or for the usual duration.

Section A	**Restriction**	**Limitation**
Physical		
Sitting	☐	☐
Standing/Walking	☐	☐
_____hrs at a time		
Lifting/Carrying	☐	☐
___ lb. allowable weight		
Pushing/Pulling	☐	☐
___ lb. allowable weight		
Climbing stairs/ladders	☐	☐
Crouching	☐	☐
Crawling	☐	☐
Kneeling	☐	☐
Bending	☐	☐
Twisting/Turning	☐	☐
Repetitive activity	☐	☐
Sustained postures	☐	☐
Gripping	☐	☐
Reaching	☐	☐
Fine dexterity	☐	☐
Balance	☐	☐

	Restriction	**Limitation**
Mental		
Thinking/Reasoning	☐	☐
Thinking/Reasoning	☐	☐
Concentration	☐	☐
Memory	☐	☐
Critical decision-making	☐	☐
Interpersonal contact	☐	☐
Alertness	☐	☐
Other (*specify in section B*)	☐	☐
Environmental		
Exposure to heat/cold	☐	☐
Exposure to dust/fumes	☐	☐
Exposure to chemicals	☐	☐
Other (*specify in section B*)	☐	☐
Other		
Shift/attendance duration	☐	☐
Shift work	☐	☐
Overtime	☐	☐
Operating vehicles/equipment	☐	☐
Working at heights	☐	☐
Work with vibrating hand tools	☐	☐
Other (*specify in section B*)	☐	☐

Section B

Please provide necessary details about any restrictions or limitations you have identified. It is not necessary to provide a diagnosis or treatment information.

_____

_____