



# Return to Work Restrictions Form

## Note to Health Care Professional

Bourgault Industries Ltd. is committed to working with health care professionals and with our team members to best manage the physical and mental health concerns of our employees, ideally within the workplace whenever reasonable. We wish 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 these 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.

With the completion of this form, a fee of **\$50.00** will be paid directly to the Health Care Professional. Please ensure all sections of this two page form are completed in its entirety.

**Completion of this form is considered the invoice for the Health Care Professional.**

## Section A

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Name of Health Care Professional (please print): \_\_\_\_\_

I saw \_\_\_\_\_ on \_\_\_\_\_  
(Patient's name) (Date)

Date of injury or illness \_\_\_\_\_  
(Date)

Date of next appointment is (indicate N/A if not applicable) \_\_\_\_\_.

The patient will be expected to return to their **next scheduled shift** with the indicated restrictions.

If medical restrictions require an **absence from accommodated duties**, the return to work date will be

\_\_\_\_\_  
(Date)

Health Care Professional Address: \_\_\_\_\_

Telephone: (306) \_\_\_\_\_

Fax: (306) \_\_\_\_\_

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

Bourgault Industries Ltd.

Tel: (306) 275-2300 Fax: (306) 275-2331 (secure line)

E-mail: [safety@bourgault.com](mailto:safety@bourgault.com)

Attention: Corporate Safety Officer



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Patient's name \_\_\_\_\_

Check  only those items that apply in Section B.

## Definitions

**Restriction:** Advised not to perform this activity in any capacity.

**Limitation:** Able to perform this activity in a reduced capacity.

**Mental Health:** In the workplace mental health concerns are subjectively reported which includes; depression, anxiety, low self-efficacy, low self-worth and perceived competency to meet job expectations. Physical injuries and medical conditions also induce anxiety, so it is natural to avoid things such as work, which then further exacerbates mental health symptoms.

## Section B

	Restriction	Limitation		Restriction	Limitation
<b>Physical – NA</b> <input type="checkbox"/>			<b>Mental Health – NA</b> <input type="checkbox"/>		
Sitting	<input type="checkbox"/>	_____ hrs	Thinking/Reasoning	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	_____ hrs	Concentration	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	_____ hrs	Memory	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	_____ kg	Critical decision-making	<input type="checkbox"/>	<input type="checkbox"/>
Carrying	<input type="checkbox"/>	_____ kg	Interpersonal contact	<input type="checkbox"/>	<input type="checkbox"/>
Pushing	<input type="checkbox"/>	_____ kg	Alertness	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	_____ kg	Additional Concerns: _____		
Climbing stairs/ladders	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Crouching	<input type="checkbox"/>	<input type="checkbox"/>			
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<b>Environmental – NA</b> <input type="checkbox"/>		
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to dust/fumes	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	Exposure to chemicals	<input type="checkbox"/>	<input type="checkbox"/>
Twisting/Turning	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other – NA</b> <input type="checkbox"/>		
Repetitive activity	<input type="checkbox"/>	<input type="checkbox"/>	Shift work	<input type="checkbox"/>	<input type="checkbox"/>
Sustained postures	<input type="checkbox"/>	<input type="checkbox"/>	Operating vehicles/equipment	<input type="checkbox"/>	<input type="checkbox"/>
Gripping	<input type="checkbox"/>	<input type="checkbox"/>	Working at heights	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	Work with vibrating hand tools	<input type="checkbox"/>	<input type="checkbox"/>
Fine dexterity	<input type="checkbox"/>	<input type="checkbox"/>	Max hours of work per day	<input type="checkbox"/>	_____ hrs
Balance	<input type="checkbox"/>	<input type="checkbox"/>			

Restrictions or limitations may affect activity for:

\_\_\_\_\_ days

\_\_\_\_\_ weeks

Unknown at this time

Additional Comments (restrictions and clarifications that are medically necessary)

Signature of Health Care Professional: \_\_\_\_\_ Date: \_\_\_\_\_