City of Kelowna

Human Resources
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Occupational Health

Fitness Form

File 2640-20 – Revised July 2011

TO BE COMPLETED BY THE EMPLOYEE – PLEASE PRINT

Name:	Job Title:
Home Phone:	Department:
Last day worked:	Date of injury or illness:
☐ Work Related ☐ Non-work related ☐ Accident \ Third Party Injury	
Do you have other employment? No ☐ Yes ☐ If yes, are you entitled to a continuance of salary from your Employer or to disability income under any other group plan? ☐	
I authorize the physician, whom I have attended, to release to the City of Kelowna Human Resources Department information requested in the physician's section of this form. The City of Kelowna may release the information on this form to any third party who has an interest in assessing my medical fitness to return to work and/or entitlement to benefits.	
Employee's Signature:	Date:

TO BE COMPLETED BY THE EXAMINING PHYSICIAN – PLEASE PRINT

The City of Kelowna is concerned about the health and well being of all employees and has a responsibility to assist in the early rehabilitation of employees experiencing an illness or injury. This assessment will assist in the accommodation of an illness/disability.
As the personal physician, you play a major role in this process by indicating as accurately as possible, the employee's work abilities and prognosis for recovery.

I saw this employee on _____ and based on his\her current health status recommend the following:

Nature of Illness \ Injury:

Fit to return with no restrictions: ☐ Yes ☐ No	Date for follow-up appointment:
Fit for modified/transitional work: ☐ Yes ☐ No	Date likely fit for unrestricted work:

Work Restrictions (please be specific):

Return to Work Abilities:

☐ Sedentary Work: Mainly seated, occasional standing, walking, lifting or carrying objects in an office setting. Lifting maximum 5 kg

☐ Light Work: Significant rotation between standing or walking, lifting. Lifting maximum 10 kg Carrying objects up to 5 kg

☐ Medium Work: Significant standing or walking, lifting. Lifting maximum 22 kg Carrying objects up to 10 kg

☐ Heavy Work: Significant standing or walking, lifting. Lifting maximum 45 kg Carrying objects up to 22 kg

Sit: ☐ 1-3 hrs ☐ 4-6 hrs ☐ full shift

Stand/Walk: ☐ 1-3 hrs ☐ 4-6 hrs ☐ full shift

Drive: ☐ 1-3 hrs ☐ 4-6 hrs ☐ full shift

The employee is able to:
☐ Push\Pull ☐ Twist ☐ Reach ☐ Climb
☐ Bend ☐ Keyboard ☐ Grasp ☐ Above Shoulders

The employee has a medical condition or treatment which affects their ability to safely operate complex heavy equipment or drive.
☐ Yes ☐ No

Physician's Name and Address:

Phone Number: Fax Number:	Physician's Signature:	Date:

Up to a maximum of $25.00 for form fee completion may be reimbursed to the employee if the OHFF is related to a work place injury.