



Community Living Society

# CLS Medical and Return to Work Form

The CLS is committed to a return to work program for employees who are recovering from illness or injury.

**The CLS can provide light duties.** (Please see reverse for general list of light duties.)

### Employee's Signature

I am authorizing any medical practitioner who treats me to provide my employer and me (and in the case of a work-related injury, WorkSafeBC) with any relevant medical information.

I understand that this information will be treated as confidential and will be used only in the management of this absence from work.

Employee Name \_\_\_\_\_

Employee's Signature \_\_\_\_\_

Date \_\_\_\_\_

Injury/Illness/Procedure Date \_\_\_\_\_  Work Related Injury  Non-Work Related Injury  Illness  Medical Procedure

### Medical Practitioner's Description of Injury or General Nature of Injury, Illness or Medical Procedure

\_\_\_\_\_  
\_\_\_\_\_

### Physical Limitation of Injured Worker (Please check all that apply.)

**Walking**  Without Limitations  
 Some Limitation (Please Specify) \*

\_\_\_\_\_  
\_\_\_\_\_

**Standing**  Without Limitations  
 Some Limitations (Please Specify) \*

\_\_\_\_\_  
\_\_\_\_\_

**Lifting**  Without Limitations  
 Some Limitation (Please Specify) \*

\_\_\_\_\_  
\_\_\_\_\_

**Carrying**  Without Limitations  
 Some Limitations (Please Specify) \*

\_\_\_\_\_  
\_\_\_\_\_

**Sitting**  Without Limitations  
 Some Limitation (Please Specify) \*

\_\_\_\_\_  
\_\_\_\_\_

**Bending**  Without Limitations  
 Some Limitations (Please Specify) \*

\_\_\_\_\_  
\_\_\_\_\_

### Repetitive Movements (arm/wrist).

Without Limitations  
 Some Limitation (Please Specify) \*

\_\_\_\_\_  
\_\_\_\_\_

Comments

\_\_\_\_\_  
\_\_\_\_\_

### Recommendation For Work Hours

Full-Time  Modified Hours (Please Specify) \_\_\_\_\_  Regular Shift

\*Graduated Hours (Please Specify) \_\_\_\_\_

\*Complete limitations to be in effect until (M/D/YY) \_\_\_\_\_

\*Estimated date of return to duties with \*some limitations (M/D/YY) \_\_\_\_\_

\*Complete recovery expected?  Yes  No

Date to be reassessed (M/D/YY) \_\_\_\_\_ or immediately

Name and phone number of attending medical practitioner (Please print and provide stamp if possible.)

\_\_\_\_\_

### NOTE

**1.)** Sick Leave will only be paid to CLS employees who hold a sick bank and who are unable to work at any CLS location or for any other employer during their absence. **2.)** If a fee is required for completion please invoice CLS by confidential fax at 604.800.0251. CLS will pay up to \$38.00 for completion of this form.

Light Duties List on reverse side...

**These light duties may be offered to the employee**  
*(this is not a limited list).*

- ⇒ **Provide transportation for supported individuals**
- ⇒ **Drive CLS van/vehicle**
- ⇒ **Complete administrative duties/paperwork**
- ⇒ **Do laundry**
- ⇒ **Do light shopping/errands**
- ⇒ **Prepare meals, set and clear tables, load and empty dishwasher**
- ⇒ **Complete lighter household tasks, dusting, sweeping and light cleaning**
- ⇒ **Complete yard maintenance task, watering, weeding, etc.**
- ⇒ **Read, socialize with supported individuals**
- ⇒ **Walk with individuals who are ambulatory**
- ⇒ **Accompany individuals out in the community**