Work Ability Assessment Form

A – PATIENT / CLIENT INFORMATION

Last name:	**First name:**	**Middle initials:**
Date of Birth (*yyyy-mm-dd*):	**Nature of illness (not diagnosis):**	

B – WORK ABILITY (PLEASE CHOOSE FROM OPTIONS BELOW)

1	☐ **Fit for regular duties**	
2	☐ **Fit for modified or alternate duties** Please identify current limitations or restrictions:	
3	☐ **Unfit for an duties** ➡ *If severe mental health condition and unable to perform any meaningful employment.*	**Expected date for graduated return to work *(yyyy-mm-dd)*:**
Date of next appointment (*yyyy-mm-dd*):		
Additional comments:		

C – HEALTH CARE PROVIDER INFORMATION

Health care provider's name:	**Health care provider's signature:**
Today's date (*yyyy-mm-dd*):	**Health care provider's phone number:**