Completing the

Functional Abilities Form (FAF)

for Planning Early and Safe Return to Work

SECTION A- WORKER/EMPLOYER INFORMATION

The worker and the employer complete this section. Proper identification, including names, addresses and phone numbers will help the WSIB process the information quickly and efficiently.

SECTION A.1. TYPE OF JOB AT TIME OF ACCIDENT

In order to plan return to work, all parties need to understand exactly what the worker was doing at the time of the injury or illness. The employer should include a detailed job description and, if available, a Physical Demands Analysis (PDA) for the worker's job. If there is no PDA available for the job, the employer may wish to use the WSIB's Physical Demands Information Form (PDIF - available on the WSIB website under "Employer Forms").

Please ensure that all areas of injury/illness are noted in this section of the FAF.

1. Type of job at time of accident (where available, please attach description of job activities)	Area(s) of injury(ies)/illness(es)

SECTION A.2. DISCUSSION OF RETURN TO WORK BETWEEN THE EMPLOYER AND WORKER

Return to work is a shared responsibility, primarily between the worker and employer. In this section of the form, the employer should indicate whether return to work discussions have taken place with the worker. If not, the date on which a return to work discussion will take place should be noted. By the employer and worker discussing RTW, the process of communication and cooperation that is essential in getting a mutually agreeable RTW plan begins.

2. Have the worker and the employer discussed Return To Work	If no, will be discussed on dd mm yyyy
☐ yes ☐ no	

A.3. NAME OF EMPLOYER CONTACT

The name and position of the employer contact is important for communication between the worker, employer, the WSIB and the health professional. Please indicate the person who is the central contact in coordinating the Return to Work plan at the workplace.

3. Employer contact name	Position

SECTION B-SIGNATURE OF THE WORKER

The worker is obligated to provide consent for the release of the functional abilities information to the employer. The worker should sign and date the form. This ensures that the worker consents to and understands the reason why the FAF information will be shared with the employer and the WSIB. It is important for the employer to explain to the worker that the shared information pertains only to his/her functional abilities as outlined on the form. No medical information is to appear on the form. It is helpful for clarity of information if the employer discusses RTW and ensures that the worker signs the FAF before it goes to the health care profesional.

B. Worker's Signature

By signing below, I am authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board (WSIB) with information about my functional abilities on the WSIB's "Functional Abilities for Planning Early and Safe Return to Work" form.

Signature	Date dd mm yyyy

WORKER/EMPLOYER

WSIB ONTARIO CSPAAT

SECTION C

This section requires information from the health professional for billing purposes. It should be mailed or faxed to the WSIB at the address/fax number listed on the front of the FAF. The completion of this form does not replace clinical reporting requirements to the WSIB. For privacy reasons, diagnostic information must never be provided on this form. The information in the shaded area of the billing section should also remain confidential to protect the health care provider's privacy.

C. Health Professional's Billing Information
For billing purposes fax or mail pages 2 and 3 to the WSIB.

INFORMATION IN SHADED AREAS SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER			
Health Professional's Designation: ☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class) ☐ Other			
Are you registered with the WSIB? ☐ Yes Please enter the nine digit **WSIB Provider ID.** in the box provided ▶ ☐ No Please call **1 - 800-569-7919** to register			**WSIB Provider ID.**
Health Professional's Name (please print)			Service Code 901
Address (No. Street, Apt.)			**Your Invoice Number**
City/Town	Province	Postal Code	Fax ( )
I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation to the WSIB.			
Health Professional's Signature	Telephone ( )		Date dd mm yyyy

SECTION D & E

These sections of the form are where the health professional identifies the worker's overall functional abilities. This information is critical for the employer and worker to be able to plan an early, safe, and successful RTW. Please complete this section in as much detail as possible so that the worker and employer can identify suitable work that can contribute to the worker's active recovery in the workplace. With detailed information about the worker's ability to lift, walk, stand, etc., the employer can identify possible job accommodations as part of a phased return to work while the worker continues to recover from the workplace injury/illness.

If the worker is physically unable to return to work and requires additional time to heal, proceed to Section F and provide the date at which the worker's condition will be re-assessed.

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment (dd mm yyyy)	2. Please check one:		
	☐ Patient is capable of returning to work with **no restrictions.**	☐ Patient is capable of returning to work **with restrictions.** Complete sections **E and F.**	☐ Patient is physically unable to return to work at this time. Complete section **F.**

E. Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3

Walking:	Standing:	Sitting:	Lifting from floor to waist:
☐ Full abilities	☐ Full abilities	☐ Full abilities	☐ Full abilities
☐ Up to 100 metres	☐ Up to 15 minutes	☐ Up to 30 minutes	☐ Up to 5 kilograms
☐ 100 - 200 metres	☐ 15 - 30 minutes	☐ 30 minutes - 1 hour	☐ 5 - 10 kilograms
☐ Other (please specify)	☐ Other (please specify)	☐ Other (please specify)	☐ Other (please specify)

Lifting from waist to shoulder:	Stair climbing:	Ladder climbing:	Travel to work:
☐ Full abilities	☐ Full abilities	☐ Full abilities	Ability to use public transit: ☐ Yes ☐ No
☐ Up to 5 kilograms	☐ Up to 5 steps	☐ 1 - 3 steps	Ability to drive a car: ☐ Yes ☐ No
☐ 5 - 10 kilograms	☐ 5 - 10 steps	☐ 4 - 6 steps	
☐ Other (please specify)	☐ Other (please specify)	☐ Other (please specify)	

2. Please indicate **Restrictions** that apply. Include additional details in section 3

- ☐ Bending/twisting repetitive movement of (please specify)
- ☐ Work at or above shoulder activity:
- ☐ Chemical exposure to:
- ☐ Environmental exposure to: (e.g. heat, cold, noise or scents)
- ☐ Limited use of hand(s): Left / Right — ☐ Gripping ☐; ☐ Pinching ☐; ☐ Other (please specify) ☐
- ☐ Limited pushing/pulling with: ☐ Left arm ☐ Right arm ☐ Other (please specify)
- ☐ Operating motorized equipment: (e.g. forklift)
- ☐ Potential side effects from medications (please specify) Do not include names of medications.
- ☐ Exposure to vibration: ☐ Whole body ☐ Hand/Arm

3. Additional Comments on **Abilities and/or Restrictions.**

4. From the date of this assessment, the above will apply for approximately: ☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Have you discussed return to work with your patient? ☐ Yes ☐ No

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours Start Date dd mm yyyy

SECTION E5

The health professional has an important role in the return to work process and can assist the worker in feeling comfortable about the importance and value of early and safe return to regular life activities, including returning to work.

5. Have you discussed return to work with your patient? ☐ Yes ☐ No

SECTION E6

Please indicate here what hours and start date are recommended for the RTW Plan.

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours Start Date dd mm yyyy

SECTION F

Please indicate date of next appointment for follow-up. This will help the employer in the process of the RTW planning and evaluation of success.

F. Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions.** ▶ dd mm yyyy

Functional Abilities Form

for Planning Early and Safe Return to Work

Health Professionals, please use this form ONLY when requested by an employer or worker.

The purpose of this form is to identify your patient's overall functional abilities and work restrictions that will assist his/her return to suitable work.

Please promptly complete and return pages 2 and 3 of this form to the worker or employer to assist the workplace parties in planning an early and safe return to work.

PLEASE ENSURE YOUR BILLING INFORMATION IS NOT GIVEN TO THE WORKER OR EMPLOYER.

Authority to Release Information

Section 37(3) of the *Workplace Safety and Insurance Act, 1997* provides the legal authority for health professionals to give the Workplace Safety and Insurance Board (WSIB), the injured worker and the employer such information as may be prescribed concerning the worker's functional abilities.

When completing this report, please **print** in **black ink**.

Worker and/or employer should complete Sections A and B of this report. If your patient needs assistance, please help. Please submit this report even if Section A is not fully completed.

Information about your responsibilities can be found on **Page 4**.

The WSIB will pay health professionals for completing this form.

Mail to:
Workplace Safety and Insurance Board
200 Front Street West
Toronto, ON M5V 3J1

OR

Fax to:
416-344-4684
or 1-888-313-7373

A guide to completing this form is available at www.wsib.on.ca

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wsib ONTARIO

Mail to:
200 Front Street West
Toronto ON M5V 3J1

or Fax to:
416 344-4684
OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

Claim No.

A. Section A to be completed by the employer and/or worker.

Worker's Last Name	First Name		Telephone
Address (no., street, apt.)	City/Town	Province	Postal Code

Employer's Name		
Full Address (No., Street, Apt.)		
City/Town	Prov.	Postal Code

Date of Birth (dd/mm/yyyy)

Date of Accident/ Awareness of Illness (dd/mm/yyyy)

Employer Telephone

Employer Fax No.

fold

1. Type of job at time of accident (where available, please attach description of job activities)	Area(s) of injury(ies)/illness(es)
2. Have the worker and the employer discussed Return To Work ☐ yes ☐ no	If no, will be discussed on dd mm yyyy
3. Employer contact name	Position

fold

B. Worker's Signature

By signing below, I am authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board (WSIB) with information about my functional abilities on the WSIB's "Functional Abilities for Planning Early and Safe Return to Work" form.

Signature	Date dd mm yyyy

C. Health Professional's Billing Information
For billing purposes fax or mail pages 2 and 3 to the WSIB.

Health Professional's Designation
☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class) ☐ Other ________

PROVIDER BILLING INFORMATION IN THE BOLDED AREA OF SECTION C SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER.

Are you registered with the WSIB?
☐ yes Please enter the **WSIB Provider ID.** in the box provided ▶
☐ no Please call **1 - 800-569-7919** to register

WSIB Provider ID.

Your Invoice Number

Service Code **FAF**

▼ Complete these fields if **HST** is applicable to this form ▼

HST Registration Number	Service Code	HST Amount Billed
	ONHST	**$.**

Health Professional's Name (please print)

Address (No. Street, Apt.)

City/Town	Province	Postal Code	Fax

I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation to the WSIB.

Health Professional's Signature	Telephone	Date dd mm yyyy

wsib ONTARIO
Mail to:
200 Front Street West
Toronto ON M5V 3J1
or Fax to:
416 344-4684
OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form for Planning Early and Safe Return to Work

Worker's Last Name	First Name	Claim No.

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.

1. Date of Assessment dd mm yyyy

2. Please check one:

- ☐ Patient is capable of returning to work with **no restrictions.**
- ☐ Patient is capable of returning to work **with restrictions.** Complete sections **E and F.**
- ☐ Patient is physically unable to return to work at this time. Complete section **F.**

E. Abilities and/or Restrictions

1. Please indicate **Abilities** that apply. Include additional details in section 3

Walking:	Standing:	Sitting:	Lifting from floor to waist:
☐ Full abilities	☐ Full abilities	☐ Full abilities	☐ Full abilities
☐ Up to 100 metres	☐ Up to 15 minutes	☐ Up to 30 minutes	☐ Up to 5 kilograms
☐ 100 - 200 metres	☐ 15 - 30 minutes	☐ 30 minutes - 1 hour	☐ 5 - 10 kilograms
☐ Other (please specify)	☐ Other (please specify)	☐ Other (please specify)	☐ Other (please specify)

Lifting from waist to shoulder:	Stair climbing:	Ladder climbing:	Travel to work:
☐ Full abilities	☐ Full abilities	☐ Full abilities	Ability to use public transit: ☐ yes ☐ no
☐ Up to 5 kilograms	☐ Up to 5 steps	☐ 1 - 3 steps	Ability to drive a car: ☐ yes ☐ no
☐ 5 - 10 kilograms	☐ 5 - 10 steps	☐ 4 - 6 steps	
☐ Other (please specify)	☐ Other (please specify)	☐ Other (please specify)	

2. Please indicate **Restrictions** that apply. Include additional details in section 3

- ☐ Bending/twisting repetitive movement of (please specify)
- ☐ Work at or above shoulder activity:
- ☐ Chemical exposure to:
- ☐ Environmental exposure to: (e.g. heat, cold, noise or scents)
- ☐ Limited use of hand(s):

Left		Right
☐	Gripping	☐
☐	Pinching	☐
☐	Other (please specify)	☐

- ☐ Limited pushing/pulling with:
  - ☐ Left arm
  - ☐ Right arm
  - ☐ Other (please specify)
- ☐ Operating motorized equipment: (e.g. forklift)
- ☐ Potential side effects from medications (please specify) Do not include names of medications.
- ☐ Exposure to vibration:
  - ☐ Whole body
  - ☐ Hand/Arm

3. Additional Comments on **Abilities and/or Restrictions.**

4. From the date of this assessment, the above will apply for approximately:
☐ 1 - 2 days ☐ 3 - 7 days ☐ 8 - 14 days ☐ 14 + days

5. Have you discussed return to work with your patient? ☐ yes ☐ no

6. Recommendations for work hours and start date: ☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours

Start Date dd mm yyyy

F. Date of Next Appointment

Recommended date of next appointment to review **Abilities and/or Restrictions.** dd mm yyyy

I have provided this completed Functional Abilities Form to: ☐ **Worker** **and/or** ☐ **Employer**

Important Information

To receive benefits, the worker must apply for benefits within six months of the date of a work-related injury or illness. When filing a claim for benefits, the worker must also consent to the disclosure of functional abilities information provided by a health professional to his or her employer for the purpose of facilitating an early and safe return to work. Failure to file a claim or provide consent for the release of the functional abilities information can result in no benefits.

If you have questions about the completion of this form please call 1-800-387-0750.

Worker's Responsibilities

- This form is to be completed by a treating health professional, who will discuss the information with you.
- Once completed, contact your employer **immediately** to review the information on the completed form. Together, you and your employer will begin to plan an early and safe return to work.

Employer's Responsibilities

- This form provides general information about this worker's functional abilities and restrictions to help you plan an early and safe return to work.
- When you provide this form to the treating health professional, ensure that you have the worker's signed consent (Section B) for the release of functional abilities information.
- Where available, also attach a description of the worker's job activities to assist the health professional in completing the form.
- The prescribed form that is available from the WSIB is a generic form developed to assist with general functional abilities information.
- The WSIB will pay the health professional to complete the prescribed WSIB form only. A charge will appear on your Accident Cost statement or Schedule 2 Invoice which reflects the cost of payment for each form completed.
- If you have a form that is specific to your workplace and have the cooperation of the worker in providing consent for the release of information on your form, you may use your own form. If you create your own form, you must reimburse the health professional directly.
- Do not send a copy of the completed Functional Abilities Form for Planning Early and Safe Return to Work to the WSIB. The health professional is responsible for submission of the form.

Health Professional's Responsibilities

- The employer and worker will use this information to plan the worker's early and safe return to work.
- Their return to work plans will reflect the functional abilities and restrictions you have noted and presume that no clinical contraindications exist for other work activities, therefore it is crucial that all sections be completed in full.
- The completion of this form is based on your examination of the worker and does not require a specialized functional abilities evaluation.
- Diagnostic or confidential information **must not** be included.
- Please add specific information on the duration of temporary restrictions or maximum times or weights to be considered, in section **E3** under **abilities and/or restrictions**. If necessary, attach an additional page to this completed form to describe abilities and restrictions.
- **Completion of this form does not replace clinical reporting requirements to the WSIB.**
- **Once you have received this form, promptly complete it and give it to the worker and/or employer.**
- **For billing purposes fax or mail pages 2 and 3 to the WSIB. When faxing, do not mail a copy.**

The WSIB will pay the health professional for the completed form when pages 2 and 3 are received.

Workplace Safety and Insurance Board
200 Front Street West
Toronto ON M5V 3J1

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