**To: Treating Physician
From: Certispec Service Inc. Management**

**Subject:** ALTERNATIVE WORK DUTIES AVAILABLE FOR INJURED EMPLOYEES

Certispec Services Inc. provides light or alternative work duties and gradual return to work options to help in the recovery and rehabilitation of employees who become injured at work.

We would like to offer your patient light or alternative duties that will keep them safely connected to the workplace while gradually returning to full work duties. Certispec Services Inc. will fully respect the limitations you set forth for this patient.

We ask that you complete the Physical Capabilities Worksheet attached to this letter to assist us in fully understanding your patient’s limitations and restrictions. Completion of this form is an uninsured medical service. There may be a fee to the patient for completion of this form. Any fees to the patient for completing this form will be coverd by Certispec Services Inc.

Sincerely,

**Glen Todd, President**
Certispec Services Inc.

208-6741 Cariboo Rd,

Burnaby, BC

V3N 4A3

Phone: [(604) 939-7070](https://www.google.com/search?source=hp&ei=X8VtXKOXDpie-gSjnrDoDw&q=Certispec%20Services%20Inc&btnK=Google+Search&oq=Certispec+Services+Inc&gs_l=psy-ab.3..35i39j0j0i22i30j38.482.4649..4802...0.0..0.292.1556.22j0j1....2..0....1..gws-wiz.....0..0i67j0i131j0i22i30i19.iE_ADYe-5bQ&npsic=0&rflfq=1&rlha=0&rllag=49248797,-122917402,130&tbm=lcl&rldimm=12924853363746655800&ved=2ahUKEwjnpeDJn8vgAhXT3J4KHZI9DLEQvS4wAHoECAAQIQ&rldoc=1&tbs=lrf:!2m1!1e2!2m1!1e3!3sIAE,lf:1,lf_ui:2)

The purpose of this form is to provide the patient with the necessary information that they need to give to their employer to help the employer make decisions about accommodating the patient, providing disability leave, or assessing if the patient can return to work.

**Notes to physician**

1. This form is not intended for Workers’ Compensation Board (WCB) purposes. For a work‑related injury or illness, the required WCB forms must be completed.

2. This form does not replace forms related to an employee’s ability to work that are required by:

* Workers’ Compensation Board,
* third‑party insurers, or
* employer‑funded medical benefit plans.

3. Where choices are indicated below, please mark your selection.

4. Please sign and date both pages 1 and 2, and keep a copy of this form.

|  |
| --- |
| Physician’s name and address (typed or printed) |
|  |
| I saw:  | On: |
| (Print patient’s name) |  (Date) |

|  |  |
| --- | --- |
| Patient was injured on (if different form date above):  |  |
| (Date) |

|  |  |
| --- | --- |
| This patient is medically able to work with limitations or restrictions as of  |  |
| (Date) |

**Restrictions or limitations (see page 2 for details)**

In my opinion, these restrictions or limitations are:

|  |  |  |
| --- | --- | --- |
| * Temporary
 | * \_\_\_\_\_\_ days
* Less than 2 weeks
* 2 to 4 weeks
 | * 4 to 6 weeks
* 6 weeks to 3 months
* More than 3 months
 |

My opinion is based on the factors indicated below:

* Information provided by the patient
* My examination of the patient and my assessment of the findings and health information

|  |  |
| --- | --- |
|  |  |
| (Physician’s signature) | (Date) |

|  |  |
| --- | --- |
| Specific functional restrictions and / or limitationsPatient’s name Check only those items that apply in Section A, and provide details in Section B. | **Definitions Restriction:** This patient is advised not to perform this activity in any capacity. Limitation: This patient is able to perform the activity in a reduced capacity. For example, the patient is not able to perform the job with the usual speed, strength or number of repetitions, or for the usual duration |
| **Section A** | **Restrictions** | **Limitations** |  | **Restrictions** | **Limitations** |
| Physical Sitting  |  |  | **Mental** |
| Mental Thinking / Reasoning  |  |  |
| Standing  |  |  | Concentration  |  |  |
| Walking |  |  | Memory  |  |  |
| Lifting |  |  | Critical decision‑making  |  |  |
| Carrying  |  |  | Interpersonal contact  |  |  |
| Pushing / Pulling |  |  | Alertness  |  |  |
| Climbing stairs  |  |  | Other (specify in section B) |  |  |
| Climbing ladders  |  |  | **Environmental** |
| Climbing scaffolding  |  |  | Exposure to heat/cold |  |  |
| Crouching  |  |  | Exposure to dust / fumes / odors |  |  |
| Crawling  |  |  | Exposure to chemicals |  |  |
| Kneeling / Bending |  |  | Other (specify in section B) |  |  |
| Twisting / Turning  |  |  | **Other** |
| Repetitive activity  |  |  | Shift / attendance duration |  |  |
| Sustained postures  |  |  | Consecutive shift attendance |  |  |
| Gripping  |  |  | Shift work |  |  |
| Reaching  |  |  | Overtime |  |  |
| Fine dexterity  |  |  | Operating vehicle |  |  |
| Balance  |  |  | Operating equipment |  |  |
| Vision / Hearing / Speech  |  |  | Working at heights |  |  |
| Other (specify in section B)  |  |  | Other (specify in section B) |  |  |

Does patient require medical aids (e.g. splint, brace) or personal protective equipment (e.g. gloves, mask)?

* No
* Yes (specify in section B)

**Section B** Please provide necessary details about any restrictions or limitations you have identified. Typically, it is not necessary to provide a diagnosis or treatment information.

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I have provided this form to the patient named above.

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| --- | --- |
|  |  |
| (Physician’s signature) | (Date) |

Section B Please provide necessary details about any restrictions or limitations you have identified. Typically, it is not necessary to provide a diagnosis or treatment information.