Appendix 9: Modified Job Description Form

Administrative Information (please print)

Employee's Name: _____ Claim #: _____

Regular Job Title: _____ Date of Accident: _____

Treating Physician: _____ Phone #:_____ Fax #: _____

Physical Restrictions

Provided By: ☐ WSIB (authorized)_____ ☐ Doctor ☐ Specialist

Documentation: ☐ Functional Abilities Form ☐ Form 7 ☐ Doctor's Note

☐ WSIB Consent Form ☐ Other _____

Proposed Duration of Restriction: _____Actual Duration:_____

Light Duties/ Modified Job Description

(The returning worker must understand that he/she is not to exceed the restrictions/ limitations detailed by the treating physician/ WSIB physician. As necessary, this Modified Job Description will be further modified to reflect the injured worker's (dis)abilities.)

Job Title:_____ **Department:** _____

Conditions:

_____

_____

_____

Weights and Sizes:

_____

_____

_____

Job Tasks:

_____

_____

_____

List Essential Duties:

_____

_____

List Non-Essential Duties:

_____

_____

Additional Notes Attached: ☐ Yes ☐ No