NON – OCCUPATIONAL

INJURY / ILLNESS STATUS REPORT (ISR)

The Corporation of the City of St. Catharines
Attention: Human Resources Coordinator
50 Church Street, P.O. Box 3012
St. Catharines, Ontario, L2R 7C2
Phone: 905.688.5601 Ext. 1487 or 1484
Confidential Fax: 905.688.9694

Employee Section:

Employee Name _____ Occupation _____ Employee Number _____

Current Contact Telephone Number _____ Alternate Contact Telephone Number _____ Date of Illness / Injury (MM/DD/YY) _____

Medical Doctor / Health Care Practitioner Section:

☐ Injury — Date of Injury (MM/DD/YY): _____
☐ Illness — Commencement of Illness (MM/DD/YY): _____
Date First Assessed for this Absence (MM/DD/YY): _____
☐ Surgery — Date of Surgery (MM/DD/YY): _____

Attention: Please complete ONLY ONE of the following three sections below:

☐ **FULL DUTIES** CAPABLE OF RETURNING TO WORK, FULL DUTIES, REGULAR HOURS, NO RESTRICTIONS
Return to Work Date (MM/DD/YY): _____

☐ **MODIFIED DUTIES** CAPABLE OF RETURNING TO MODIFIED DUTIES AND / OR HOURS:
Return to Work Date (MM/DD/YY): _____ Duration of Modified Duties: _____

ABILITIES: **Please indicate Abilities that apply. Include additional details in comments section.**

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 to 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	☐ Able to use public transit
☐ Up to 5 kilograms	☐ Up to 5 steps	☐ 1 – 3 steps	☐ Able to drive a car
☐ 5 – 10 kilograms	☐ 5 – 10 steps	☐ 4 – 6 steps	☐ Other (please specify)
☐ Other (please specify)	☐ Other (please specify)	☐ Other (please specify)	_____

RESTRICTIONS: **Please indicate ONLY restrictions that apply. Include additional details in comments section.**

☐ 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 ☐ 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

☐ **UNABLE TO RETURN TO WORK**
Please list the restrictions that are preventing the patient from returning to modified / full duties:
Please estimate when the patient may return to modified / full duties: _____

COMMENTS (on reverse if necessary):

Have you reviewed the above information with your Patient? Yes ☐ No ☐

Is the patient following prescribed medical treatment? Yes ☐ No ☐

Date of next appointment for review (MM/DD/YY): _____

Certified by Medical Doctor / Health Care Practitioner:

NAME / ADDRESS/ STAMP

Signature _____ **Date (MM/DD/YY)** _____