OFFICE OF RESIDENT AFFAIRS AND PHYSICIAN WELLNESS – Fitness for Work Form

TO BE COMPLETED BY MEDICAL LEARNER:			
Name:		Date of Birth:	
UCID:		Pronouns:	
Email:		Phone #:	
Program:		PGY:	
Program Director:			

This information is being collected under the authority of Section 33(c) of the *Alberta Freedom of Information and Protection of Privacy Act (FOIP*). It is required to determine and advise on appropriate accommodation. This information will be accessible to members of the PGME Accommodations Assessment Committee, and the PGME Accommodations Therapist, and to the Senior Associate Dean, Education in the event of a request for review pursuant to 4.29-4.35 of the Process. If the effort to identify a Reasonable Accommodation requires us to inform anyone else, we will request your permission to share. If you have questions about the collection or use of this information, please contact the office of the Associate Dean, PGME, Room G02 (Ground Floor), Heritage Medical Research Building, 3330 Hospital Drive NW at (403) 220-4860.

Medical Learner Signature:		Date:	

DEAR PHYSICAN:

The University of Calgary provides an opportunity for Medical Learners to seek and obtain accommodations in their Postgraduate Medical Education (PGME) Training Program. This process:

a) defines potential accommodations in the PGME Training Program which balance the objectives of enabling Medical Learners to complete their training and meaningfully participate in the medical profession while safeguarding Patient Care, Safety and Well-Being; and
b) sets out the Cumming School of Medicine's expectations for the accommodation process in respect of Medical Learners who are experiencing barriers related to a Protected Ground.

The Office of Resident Affairs and Physician Wellness provides services to support the Medical Learner through the Accommodations Process and throughout their PGME Training Program. We appreciate your attention to this form. The information you provide will not become part of the Learner's educational record but will be kept in their confidential file in the Office of Resident Affairs and Physician Wellness.

TO BE COMPLETED BY PHYSICIAN (Please complete applicable areas)			
Date of symptom onset:		Is the condition: ☐ Acute	☐ Chronic
Is the recommended accommodation:		☐ Temporary	☐ Permanent
If temporary, please indicate the anticipated duration or reassessment date:			
Has an active treatment plan been prescribed?		☐ Yes	☐ No
Is the patient compliant with the treatment plan?		☐ Yes	☐ No
Are there considerations preventing patient compliance with the treatment plan? (Please explain)			

Please indicate the current physical work abilities:					
	Able	**Unable**	**Limited to:**		
Lifting Floor to Waist	☐	☐	Max ____ lbs	☐ Frequently	☐ Occasionally
Lifting Waist to Shoulder	☐	☐	Max ____ lbs	☐ Frequently	☐ Occasionally
Lifting Above Shoulder	☐	☐	Max ____ lbs	☐ Frequently	☐ Occasionally
Pushing / Pulling	☐	☐	Max force: ____ lbs	☐ Frequently	☐ Occasionally
Reaching Above Shoulder	☐	☐	☐ Left ☐ Right	☐ Frequently	☐ Occasionally
Reaching Below Shoulder	☐	☐	☐ Left ☐ Right	☐ Frequently	☐ Occasionally
Use of Hands	☐	☐	☐ Left ☐ Right	☐ Frequently	☐ Occasionally
Standing	☐	☐	_____ mins	☐ At a time	☐ Cumulative
Walking	☐	☐	_____ mins	☐ At a time	☐ Cumulative
Sitting	☐	☐	_____ mins	☐ At a time	☐ Cumulative
Bending	☐	☐	☐ Frequently	☐ Occasionally	
Twisting	☐	☐	☐ Frequently	☐ Occasionally	
Squatting / Kneeling	☐	☐	☐ Frequently	☐ Occasionally	
Climbing	☐	☐	☐ Frequently	☐ Occasionally	
Additional comments to the above work abilities:					
Is an occupational assessment recommended to determine physical capabilities?			☐ Yes	☐ No	

Please indicate the current cognitive work abilities according to the definitions below:

No Impact – No accommodation necessary
Mild – Mild limitations evident. Medical Learner should be able to cope with minimal supports.
Moderate – Symptoms are prominent. Medical Learner requires a degree of accommodation.
Serious – Symptoms interfere with ability to function. Medical Learner requires significant accommodations.
Unknown – Not known at this time

	No Impact	**Mild**	**Moderate**	**Serious**	**Unknown**
Concentration / Focus	☐	☐	☐	☐	☐
Memory	☐	☐	☐	☐	☐
Energy / Alertness	☐	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐	☐
Comprehension / Communication	☐	☐	☐	☐	☐
Decision Making / Judgment	☐	☐	☐	☐	☐
Managing internal distractions	☐	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐	☐
Organisation/time management	☐	☐	☐	☐	☐
Additional comments to the above work abilities:					

Please indicate the current work abilities regarding work hours				
☐ Maximum number of hours / week:			☐ Maximum number of hours / day:	
Able to work call / shift work	☐ Yes	☐ No	☐ With limitations (Please indicate below)	

Limitation (If applicable)	Comments (Please provide specifics for each limitation)
☐ Frequency of call shifts	
☐ Minimum time between call shifts	
☐ Requires protected time pre-call shift	
☐ Requires protected time post-call shift	
☐ Maximum length of call shift	
☐ Overnight Call Shift	☐ No overnight call ☐ Night call until _____ o'clock ☐ Other considerations:

Additional comments to the above work abilities:

Medical Follow-up			
Is medical follow-up required?	☐ Yes, Date:		☐ No
Is protected time required for medical appointments?	☐ Yes (Please explain)		☐ No

Additional Comments
Other Recommended Accommodations (Please describe)
Length of Time for Accommodations to be implemented:

Physician Information			
Physician Name			
Physician Address			
Physician Phone #			
Physician Signature:		Date:	