

In order to identify my functional abilities, and whether I have any restrictions or limitations that will need to be accommodated in order to help me remain at, or return to work:

I, [Click or tap here to enter text.], authorize [departmental return to work (RTW) point of contact’s name], and [insert telephone number] to contact [print name of physician or health care practitioner] in order to:

* Request completion of a [Functional Abilities Form](https://www.canada.ca/en/government/publicservice/wellness-inclusion-diversity-public-service/health-wellness-public-servants/disability-management/functional-abilities-form.html);
* Obtain a copy of a completed Functional Abilities Form; and/or
* Obtain clarification with respect to the restrictions, limitations and/or the duration of restrictions or limitations identified on a Functional Abilities Form.

No diagnosis or treatment information is to be shared with [department].

For the purposes of developing, implementing or seeking approval of a remain-at, or return-to-work plan, and to identify any accommodation measures that may be required, my functional abilities information may be shared among:

* my supervisor/manager; the unit/local Return to Work Committee (if applicable); the appointed disability management advisor; or authorized human resources officer, within [department]; or
* my insurer (occupational or non-occupational) if applicable.

Employee’s name: (please print)

Address: Click or tap here to enter text.

Home Tel: Click or tap here to enter text.

Work Tel: Click or tap here to enter text.

Signature: Click or tap here to enter text.

Date: Click or tap to enter a date.

Witness name: (please print)

Address: Click or tap here to enter text.

Home Tel: Click or tap here to enter text.

Work Tel: Click or tap here to enter text.

Signature: Click or tap here to enter text.

Date: Click or tap to enter a date.