CUSTODIAL MEDICAL REPORT

School District 10, Arrow Lakes
(t) (250) 265-3638 ext. 3301 (fax) (250) 265-3701

I authorize the physician, whom I have attended, to release to School District 10 Human Resources Department information requested in the physician's section of this form. School District 10 may release the information contained on this form to any third party who has an interest in assessing my medical fitness to return to work and/or entitlement to benefits.

Employee's Name: ***(please print)*** _____ **Signature:** _____

Name of attending Physician ***:(please print)*** _____

Physical limitations of injured worker:

Lifting:
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ Up to 5 lbs.
  - ☐ Up to 10 lbs.
  - ☐ Up to 20 lbs.
- ☐ No lifting

Wet Mop:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No wet mopping

Snow Removal:
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐½ hr per day
  - ☐1 hr per day
- ☐ Hand plowing only
- ☐ No Shoveling
- ☐ Snow Blowing (large machine)
  - ☐½ hr per day
  - ☐1 hr per day
- ☐ Snow Blowing (small machine)
- ☐ No machine snow blowing

Sweeping:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No sweeping
- ☐ No side to side sweeping

Repetitive Movements *(arms/wrists/ shoulders/back):*
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ Some restrictions
- ☐ No above shoulder height work
- ☐ No below waist height work
- ☐ No arm extension
- ☐ No repetitive movements

Standing:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No standing

Ladders:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No ladders

Carrying:
- ☐ Without restrictions
- ☐ Some restrictions
  - ☐ Up to 5 lbs.
  - ☐ Up to 10 lbs.
  - ☐ Up to 20 lbs.
- ☐ No carrying

Bending:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No bending

Push/Pull:
- ☐ Without restrictions
- ☐ No pushing
- ☐ No pulling

Dry Mop:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No dry mopping
- ☐ No side to side dry mopping

Scrubber:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No scrubber

Sedentary Clerical Work:
- ☐ Without restrictions
- ☐ Some restrictions
- ☐ No sedentary work

Please specify any work restrictions *(as identified above):* _____

_____

Duration of restriction(s): ☐ day(s) ☐ week(s)

Anticipated date able to return to full duties: _____

Physician: *(Signature)* _____ **Date:** _____

Physician's Address: _____ **Physician Phone Number:** _____