Employee Health and Accommodations - University of Waterloo
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FUNCTIONAL LIMITATION VERIFICATION FORM

TO BE COMPLETED BY EMPLOYEE

This form is to be completed by you and your practitioner (e.g. Occupational Therapist, Social Worker, Speech-Language Pathologist, traditional healer) who has in-depth knowledge of your functional limitations. The purpose is to identify functional limitations that are causing barriers in the workplace environment, which may require an accommodation. This form is most appropriate for individuals where a disability diagnosis has not been, or may not be, established, yet there is a presence of functional limitations that may impact you in the workplace.

Please note: any costs associated with obtaining or providing this documentation are the responsibility of the employee.

SECTION 1: EMPLOYEE INFORMATION

EMPLOYEE INFORMATION (PLEASE PRINT)	
First and Last Name:	
WAT IAM	
UWaterloo Email (WAT IAM)	@uwaterloo.ca
Personal Email Address (required)	

SECTION 2: CONFIDENTIALITY & AUTHORIZATION FOR RELEASE OF INFORMATION

Information provided in this form, is kept ***strictly confidential***. It is not shared with anyone outside of Employee Health and Accommodations, including with other university departments, without the expressed and written consent and/or direction of the employee. Please note that your practitioner will also maintain a copy of this document in your file with them.

By submitting this form, I authorize the attending health care professional / practitioner named in this form to complete the Functional Limitation Verification Form and disclose information concerning myself to Employee Health and Accommodations.

By signing below, I give consent for Employee Health and Accommodations to contact the service provider who completed this form to discuss information provided in this document, if necessary, to clarify information regarding functional limitations or if there are questions related to my application.

Employee's signature:	Date:

Employee's informed authorization for disclosure of information is obtained in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), -s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information.

TO BE COMPLETED BY HEALTH CARE PRACTITIONER

This form is most appropriate for individuals where a **disability diagnosis has not been, or may not be, established**, yet there is a presence of functional limitations that may impact you in the workplace. This form is also appropriate for individuals working with **a health care provider who has in-depth knowledge of your functional limitations**, but who may not have the authority to communicate a diagnosis **(e.g. Occupational Therapist, Social Worker, Psychotherapist, Speech-Language Pathologist, Elder or traditional healer).**

The University of Waterloo requires your detailed assessment of this employee's functional limitations, especially how **limitations or restrictions may impact their ability to access and participate in their workplace environment.** Careful consideration should be given to the **verification of disability** and **degree of functional limitations** in the sections below.

SECTION 3: ASSESSMENT INFORMATION

1. Are there functional limitations related to any of the following?
   - ☐ Physical disability/condition
   - ☐ Mental health disability/condition
   - ☐ Acquired brain injury (e.g. concussion) disability/condition
   - ☐ Neurodivergent disability/condition
   - ☐ Hard of hearing disability/condition
   - ☐ Visual disability/condition
   - ☐ Other:

2. Diagnosis(es)*: (OPTIONAL)
   ***Please only include this information when the diagnosis(es) was established by a practitioner legally qualified to do so (e.g. Physician, Psychologist) AND where the employee consents to disclosing this information.**
   Diagnosis(es):

   Name of Diagnosing Practitioner:

   Position/Title:

3. Please indicate (if known) the onset of the applicant's functional limitations (i.e., when the applicant began experiencing symptoms and challenges in the workplace environment):

4. How long have you been **regularly** evaluating the applicant for the presenting concerns?

5. How many times have you assessed the applicant for the presenting concerns?

6. Will you be monitoring/treating the applicant going forward? ☐ Yes ☐ No

SECTION 4: DURATION OF ASSOCIATED FUNCTIONAL LIMITATIONS

- ☐ **Permanent, continuous:** Ongoing functional limitations that will impact the applicant over the course of their career and are unlikely to change
- ☐ **Permanent, episodic:** Periods of good health interrupted by periods of illness or disability over the course of their career
- ☐ **Temporary:** These functional limitations are temporary, or the severity may change, and should be reassessed in future. Applicant to be reassessed by:
- ☐ **Provisional:** I am still monitoring/assessing the applicant. Assessment likely to be completed by:
- ☐ **No disability:** The symptoms do not constitute a medical condition, or the medical condition is non-disabling in the workplace environment

SECTION 5: FUNCTIONAL LIMITATIONS IN THE WORKPLACE ENVIRONMENT

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Attention/concentration	☐	☐	☐	☐	☐	
Short-term memory	☐	☐	☐	☐	☐	
Long-term memory *(please attach testing results)*	☐	☐	☐	☐	☐	
Information processing (verbal)	☐	☐	☐	☐	☐	
Information processing (written)	☐	☐	☐	☐	☐	
Managing distractions (internal)	☐	☐	☐	☐	☐	
Managing distractions (external)	☐	☐	☐	☐	☐	
Managing emotions/stress	☐	☐	☐	☐	☐	
Executive Functioning						
Organization	☐	☐	☐	☐	☐	
Planning	☐	☐	☐	☐	☐	
Problem solving	☐	☐	☐	☐	☐	
Sequencing	☐	☐	☐	☐	☐	
Time management	☐	☐	☐	☐	☐	
Mobility /Physical Activities						
Sitting (<60min)	☐	☐	☐	☐	☐	
Sitting (>60min)	☐	☐	☐	☐	☐	
Standing (>15min)	☐	☐	☐	☐	☐	
Walking (<500m)	☐	☐	☐	☐	☐	
Walking (>500m)	☐	☐	☐	☐	☐	
Stairs (1 flight)	☐	☐	☐	☐	☐	
Lifting	☐	☐	☐	☐	☐	
Reaching	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Bending	☐	☐	☐	☐	☐	

Area	None	Mild	Moderate	Severe	Unknown/ Cannot Assess	Comments/Additional Information
Working At Heights (i.e. ladders, platforms)	☐	☐	☐	☐	☐	
Fatigue	☐	☐	☐	☐	☐	
Dexterity / Fine Motor Movements	☐	☐	☐	☐	☐	
Handwriting	☐	☐	☐	☐	☐	
Dominant L or R (specify: _____)	☐	☐	☐	☐	☐	
Typing/keyboarding	☐	☐	☐	☐	☐	
Reading	☐	☐	☐	☐	☐	
Listening	☐	☐	☐	☐	☐	
Speaking	☐	☐	☐	☐	☐	
Pain	☐	☐	☐	☐	☐	
Other: _____	☐	☐	☐	☐	☐	

Additional information: Please use this space to provide any other information about the applicant's disability and their functional limitations that the University of Waterloo should consider regarding their workplace accommodation needs:

CERTIFICATE OF ATTENDING PRACTITIONER

Documentation completed by a relative of the patient/employee will not be accepted due to professional and ethical considerations even when the practitioner is otherwise qualified to do so. The practitioner signing this form must be the same person answering the questions on the form above.	
Name of practitioner:	
Position/title:	Organization (if external):
Please check all that apply to you: ☐ Member of the College of Audiologists and Speech-Language Pathologists of Ontario ☐ Member of the College of Chiropractors of Ontario ☐ Member of the College of Naturopaths of Ontario ☐ Member of the College of Nurses of Ontario ☐ Member of the College of Occupational Therapists of Ontario ☐ Member of the College of Physicians and Surgeons of Ontario ☐ Member of the College of Physiotherapists of Ontario ☐ Member of the College of Psychologists of Ontario ☐ Member of the College of Social Workers and Social Services Workers ☐ Member of the College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario ☐ First Nations, Inuit & Metis Traditional Healer/Elder ☐ Other:	
Email address:	Phone number:
Practitioner signature:	Date: