# Stay At or Return to Work Form 111

*The purpose of this form is to provide information to assist the employee to stay at work if possible, or plan for the employee's safe return to work at the earliest possible date.*

Last revised: January 2025
Last reviewed: January 2025
**Next review: January 2027**

## FOR EMPLOYEE COMPLETION

The Government of Saskatchewan is committed to an inclusive workplace and a workforce representative of our diverse province. This means providing an effective medical accommodation process for employees experiencing illness, injury or disability and helping ministries administer the Employee Accommodation Policy.

Through the Be At Work Program, the Government of Saskatchewan is committed to:

- Ensuring a safe recovery at work or a safe early return to work for all employees, including providing meaningful productive work within medical restrictions after an employee has sustained an injury or illness; and
- Ensuring new and existing employees with disabilities receive the support they need to be successful in their roles and workplaces.

For more information, please visit the Be At Work Program page on Taskroom.

**If you are absent from work for more than 5 working days due to illness or a non-work-related injury, are injured at work or require a medical accommodation in the workplace due to a disability, you are required to:**

1. Report the incident, illness, injury or disability to your manager/supervisor. If this is a workplace illness or injury, complete Form 101 Incident Reporting and Investigation in PSC Client.
2. Complete the *"For Employee Completion"* section below and have your employer complete the "*For Employer Completion*" section on the next page. Please note these sections need to be completed before providing Form 111 to your Licensed Health Care Practitioner.
3. After signing the Employee Authorization section on page 3, meet with your Licensed Health Care Practitioner and provide them with Form 111, including the completed Employee/Employer sections of the form. Discuss thoroughly and have them complete the "*For Physician/Licensed Health Care Practitioner Completion*" section of the form.
4. Take the completed form and return it to your manager/supervisor or as instructed by the employer on page two.
5. Participate in the medical accommodation process along with your manager/supervisor.

I authorize the Licensed Health Care Practitioner involved with my treatment to complete this form and provide my employer with information about my objective medical limitations and restrictions affecting my work abilities. My authorization is strictly limited to the current medical condition. I declare that my consent to the release of my personal health information has been given voluntarily.

| Name | Last day worked (if applicable) |
|---|---|
| Employee Signature | Date |



Saskatchewan

## FOR EMPLOYER COMPLETION

Complete this section prior to your employee taking Form 111 to their Licensed Health Care Practitioner. This will ensure the Licenced Health Care Practitioner is aware of the employee's regular core job duties.

Please discuss a reasonable timeframe with your employee to return the completed Licensed Health Care Practitioner section of this form.

Subsection 24.1 of *The Freedom of Information and Protection of Privacy Act* (FOIP) and section 16 of *The Health Information Protection Act* (HIPA) places "Duty to Protect" personal information and personal health information on government institutions and trustees. In compliance with FOIP and HIPA, Public Service Commission asks the Manager/Supervisor/Ministry Accommodation Representative/Medical Accommodation Consultant check "Section 705: Employment Accommodation" policy, and instructions within the "Be At Work Application" to handle information received through this form with upmost care and restrict sharing only on need-to-know basis.

Once the completed Form 111 is returned, please upload the information to the Be At Work Application in PSC Client.

For more information, please visit the Be at Work Program page on Taskroom.

Please provide a brief description of the employee's regular core job duties (attach job demands):

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Employee to return this form by: _____ to: _____

Name and Title of Manager/Supervisor

Address

Subsection 24.1 of *The Freedom of Information and Protection of Privacy Act* (FOIP) and section 16 of *The Health Information Protection Act* (HIPA) places "Duty to Protect" personal information and personal health information on government institutions and trustees. In compliance with FOIP and HIPA, Public Service Commission asks that only limited and need to know personal information and personal health information be shared with the employer. Do not share diagnosis in completing this form.

## FOR PHYSICIAN/LICENSED HEALTH CARE PRACTITIONER COMPLETION

Approximate date disability, illness or injury began: _____

Date of Exam (dd/mm/yy): _____ Date of next appointment: _____

❑ Patient is **FIT for REGULAR DUTIES/ALL ESSENTIAL DUTIES and FULL WORK SHIFT**

❑ Patient is **FIT for GRADUATED WORK SCHEDULE:** hrs/day _____ for week(s) _____
❑ Patient is **FIT for MODIFIED/ALTERNATE DUTIES**

**ESTIMATED DURATION OF RESTRICTIONS/MODIFIED DUTIES:** _____ **week(s) or** _____ **day(s)**

❑ Patient is not fit but **expected to RECOVER FULLY**; Anticipated return to work date: _____
❑ Patient is **NOT expected to return to work.**

If your patient is not presently fit to return to work or requires accommodation in the workplace, please complete Part A and B.

### A. FUNCTIONAL/PHYSICAL LIMITATIONS (select all that apply)

| | |
|---|---|
| **Walking**<br>❑ No limitations<br>❑ Limited uneven ground<br>❑ No prolonged periods over 30 minutes<br>❑ Not more than 100 meters<br>❑ Unable to walk with/ without assistance (cane, crutches).<br>Please explain: | **Strength (lifting carrying, pushing, pulling)**<br>❑ No limitations<br>❑ Heavy – over 20kg occasionally<br>❑ Medium – up to 10kg regularly and 20 kg occasionally<br>❑ Light – up to 5kg regularly and 10kg occasionally<br>❑ Sedentary – up to 5kg occasionally |
| **Postures**<br>❑ No limitations<br>❑ Must be able to change from sitting to standing<br>❑ No sitting duration over 30 minutes<br>❑ No standing duration over 30 minutes | **Climbing and Balance**<br>❑ No limitations<br>❑ Stairs only<br>❑ No vertical ladders<br>❑ No working at heights (over 6 feet) |
| **Upper Limbs**<br>❑ No limitations<br>❑ No above shoulder reaching ❑ left ❑ right<br>❑ No firm gripping or twisting ❑ left ❑ right<br>❑ No writing or keyboard use ❑ left ❑ right | **Operation Moving Equipment / Driving**<br>❑ Can operate moving equipment<br>❑ Cannot operate moving equipment |
| Does your patient require any physical, technical and/or communication accessibility accommodations? ❑ Yes ❑ No<br>If yes, please identify the barriers: | |

| **B. COGNITIVE/SOCIAL/EMOTIONAL LIMITATIONS (select all that apply)** | | |
|---|---|---|
| ❑ Memory<br>❑ Judgment<br>❑ Alertness<br>Provide details: | ❑ Speech<br>❑ Hearing<br>❑ Communication<br>Provide details: | ❑ Affect / Disposition<br><br>Provide details: |
| **Attention to detail:**<br>❑ Concentration on detail severely limited.<br>❑ Concentration on detail limited.<br>❑ Can concentrate on detail with occasional breaks of non-detailed work.<br>❑ Maintains their usual ability to concentrate on detail. | **Performance of overlapping tasks:**<br>❑ Can handle only one task at a time.<br>❑ Can handle more than one task.<br>❑ Can handle multiple tasks; requires additional time.<br>❑ Maintains their usual ability to handle multiple tasks. | **Tolerance to external stimulus:**<br>❑ Needs quiet, non-distracting work environment.<br>❑ Can cope w/ small degree of distraction.<br>❑ Can cope with distracting stimuli for a portion of the day.<br>❑ Maintains their usual level of tolerance. |
| **Supervision required:**<br>❑ Needs constant supervision.<br>❑ Needs frequent supervision.<br>❑ Needs limited supervision.<br>❑ Needs their usual level of supervision. | **Supervision of others:**<br>❑ Not able to supervise.<br>❑ Can supervise a small group consisting of ____ people.<br>❑ Capable of regular supervisory duties. | **Tolerance of deadlines:**<br>❑ Cannot deal with deadline pressure.<br>❑ Occasionally deal with deadlines.<br>❑ Can deal with recurring deadlines.<br>❑ Maintains their usual level of tolerance. |
| **Responsibility and accountability:**<br>❑ Can exercise a moderate level of responsibility with occasional need for support.<br>❑ Can handle their usual level of responsibility and accountability. | **Coping with confrontation:**<br>❑ Unable to cope with confrontational situations.<br>❑ Moderate ability to cope with confrontational situations.<br>❑ Maintains their usual ability to cope with confrontational situations. | **Ability to work with others cooperatively:**<br>❑ Tolerates working alone.<br>❑ Can tolerate others within vicinity.<br>❑ Can work with others cooperatively. |
| Is your patient taking any medication that would affect their ability to perform their job duties safely? ❑ Yes ❑ No<br>If yes, please identify the restrictions: | | |

| **COMMENTS (do not include diagnosis)** |
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|---|---|---|
| Practitioner's Printed Name | Practitioner's Signature | Date |
| Professional Designation | Address | Telephone Number |