Functional Abilities Form (FAF)

To support a safe return to work.

WORK CONNECTIONS
UNIVERSITY OF MICHIGAN
Illness and Injury Assistance

Name of Patient	Date of Birth	SSN

A. RECOMMENDATIONS for RETURN TO WORK

1. Have you discussed return to work with your patient? ☐ Yes ☐ No
   Please explain:

2. Does your patient require assistance or retraining in preparing for return to full duties, etc.? ☐ Yes ☐ No
   Please explain:

3. Recommendations for work hours and start date:

   ☐ Regular full-time hours effective _____.

   ☐ Modified hours effective _____, _____ hours/day and/or _____ hours/week.

   ☐ Graduated hours effective _____, _____ hours/day for_____ week(s), then _____ hours/day for _____ week(s).

4. Recommended date of next appointment to review abilities and/or restrictions:

B. ABILITIES AND LIMITATIONS – Include comments in Section C

5.

Walking:
☐ Full abilities
☐ Up to 2 hours/day
☐ Up to 4 hours/day
☐ Other (please specify)

Standing:
☐ Full abilities
☐ Up to 2 hours/day
☐ Up to 4 hours/day
☐ Other (please specify)

Sitting:
☐ Full abilities
☐ Up to 2 hours/day
☐ Up to 4 hours/day
☐ Other (please specify)

Lifting from floor to waist:
☐ Full abilities
☐ Up to 10 lbs.
☐ 10 – 20 lbs.
☐ Other (please specify)

Lifting from waist to shoulder:
☐ Full abilities
☐ Up to 10 lbs.
☐ 10 – 20 lbs.
☐ Other (please specify)

Stair Climbing:
☐ Full abilities
☐ 1 - 2 flights at a time
☐ 3 - 4 flights at a time
☐ Other (please specify)

Ladder climbing:
☐ Full abilities
☐ None
☐ Limited to
_____

Travel to work:
Ability to use Public transit
☐ Yes ☐ No

Ability to drive a car
☐ Yes ☐ No

Cognitive limitations:
☐ Full abilities
☐ Memory
☐ Concentration
☐ Fatigue
☐ Interaction with others
☐ Other (please describe)

Bending/twisting repetitive movement:
☐ Full abilities
☐ None
☐ Limited to
_____

Work above chest/ shoulder level: R L
☐ Full abilities
☐ None
☐ Limited to
_____

Forceful or repetitive grasping with: R L
☐ Full abilities
☐ None
☐ Limited to
_____

Pushing/pulling with: R L
☐ Full abilities
☐ None
☐ Limited to
_____

Kneeling or squatting:
☐ Full abilities
☐ None
☐ Limited to
_____

Operating motorized equipment (i.e. forklift):
☐ Full abilities
☐ None
☐ Limited to _____

Other:

C. COMMENTS – Abilities and Limitations

6. Additional comments on abilities and limitations listed above:

7. From the date of this assessment, the abilities and limitations noted above will expire on:

D. PHYSICIAN'S INFORMATION

Physician's Name (please print):	Physician's Signature:	Date:
		Email:
Degree/Specialty:	Address:	Phone:
		Fax:

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