

## Activity Limitations Form

2025

|                        |  |                          |  |
|------------------------|--|--------------------------|--|
| <b>Associate Name:</b> |  | <b>Associate Number:</b> |  |
| <b>Store Number:</b>   | <b>Date of Injury/Illness:</b> ___/___/___<br>DD MM YY | <b>Claim Number:</b>     |  |

**Authorization and Signature:**  
 By signing below, I am authorizing any health care professional who treats me to provide my employer and I with information about my functional abilities on the Stitch It's Activity Limitations Form. I also authorize this information to be used for the purposes of return to work, and condone the sharing of this information to all relevant parties including, but not limited to: insurance providers, Workers' Compensation Board, independent health care professionals, etc.

**Associate Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### To Be Completed By Health Care Professional:

Is the Associate capable of returning to work immediately without limitations?  Yes  No  
 If no, please complete the section below:

| TASK                    | Task Breakdown:  | Ability |     |    |
|-------------------------|--|---------|-----|----|
|                         |  | Yes     | Mod | No |
| Prepping*               | All tasks are carried out intermittently throughout the shift                |         |     |    |
|                         | Intermittent standing  |         |     |    |
|                         | Usual forward reach of less than 30cm  |         |     |    |
|                         | Over-head reaching   |         |     |    |
| Bagging/Pressing*       | Lifting garments to table and carrying them to racks (1 to 4kg)              |         |     |    |
|                         | Shoulder height reaching   |         |     |    |
| Fitting*                | Micro movements of arms and hands  |         |     |    |
|                         | Minor forward and overhead lifting and reaching                              |         |     |    |
|                         | Intermittent standing  |         |     |    |
| Customer Service*       | Intermittent kneeling/crouching  |         |     |    |
|                         | Intermittent sitting on stool, if applicable                                 |         |     |    |
|                         | Reaching / Reaching to pin - shoulder flexion generally less than 30 degrees |         |     |    |
|                         | Over-head and shoulder reaching and lifting (1 to 4 kg) as necessary         |         |     |    |
| Sewing Production Roles | Shoulder height reaching as necessary  |         |     |    |
|                         | Intermittent standing  |         |     |    |
|                         | Sitting on adjustable stationary chair                                       |         |     |    |
|                         | Sustained minor neck flexion   |         |     |    |
|                         | Frequent micro-movements of arms and hands                                   |         |     |    |
| Adm Work                | Sustained minor forward spinal flexion                                       |         |     |    |
|                         | Occasional reaching with right arm to operate sewing machine                 |         |     |    |
|                         | Light knee pressure for operation of machine                                 |         |     |    |
|                         | Sedentary administrative duties  |         |     |    |

|                                       |                  |                             |                            |
|---------------------------------------|------------------|-----------------------------|----------------------------|
| <b>Recommendation for Work Hours:</b> | <b>Regular</b>   |                             |                            |
|                                       | <b>Graduated</b> | Start at ___ hours per week | Start at ___ days per week |
|                                       | <b>Modified</b>  | Start at ___ hours per week | Start at ___ days per week |

|                                |   |
|--------------------------------|---|
| <b>Area of Injury/Illness:</b> | <b>Estimated duration of limitations:</b> |
|--------------------------------|---|

|   |   |
|---|---|
| <b>Health Care Professional's Name and Specialty (Print):</b> | <b>Next Assessment:</b> ___/___/___<br>DD MM YY |
|---|---|

**Full Address:**

|                         |                   |              |                         |
|-------------------------|-------------------|--------------|-------------------------|
| <b>Phone No.:</b> ( ) - | <b>Signature:</b> | <b>Date:</b> | ___/___/___<br>DD MM YY |
|-------------------------|-------------------|--------------|-------------------------|

**Comments:**