Work ability assessment request

This form is intended to be completed when an employer requests an occupational health service to assess an employee's work ability. A work ability assessment may be requested, for example, when early support measures have not been sufficient to resolve challenges related to the employee's ability to cope at work, and there is concern about the employee's functional capacity from a health perspective in relation to job demands. The occupational health physician prepares a written assessment of the patient's work ability or fitness for work, and the employee submits it to their supervisor.

It is recommended that the supervisor and the employee complete the form together.

Personal and workplace information

Employee name: _____

Personal identity number: _____

Work unit: _____

Job title: _____

Description of duties:

Employment details

Started in current position: _____ / _____ / _____

Started in current work unit: _____ / _____ / _____

Permanent / Fixed term until: _____ / _____ / _____

Weekly working hours:

_____

Night shifts: _____

JÄRVISEUDUN JA KALLAVEDEN
TYÖTERVEYS

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Supervisor's assessment of work performance

Why is the supervisor requesting a work ability assessment?
Supervisor's description of the employee's work ability and any challenges identified:

Employee's competence, resources and strengths

What the employee does well: _____

Areas for development: _____

Assessment (tick according to your evaluation)
1 = poor, 5 = excellent

Interaction skills:

a) with clients/patients etc.	Tick your evaluation
b) with colleagues	Tick your evaluation
Motivation:	Tick your evaluation
Mental coping:	Tick your evaluation
Physical coping:	Tick your evaluation

When did the decline in work ability begin? _____

Have work arrangements been made to support work ability? ☐ Yes ☐ No

If yes, what and when?

Have they been helpful? _____

Sick leave days during the past 6 months:

Discussion according to the early support model held: _____

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The employee will be referred to Järviseudun Työterveys.

What has been agreed, and who will make contact? _____

Supervisor: _____

Phone number: _____

Email: _____

Supervisor's job title: _____

Signatures

Date and place:

_____ _____

Employee signature and printed name

_____

Supervisor's signature and printed name

_____

The form is printed and sent to the occupational health nurse responsible for the unit.