Fitness for Professional Practice form

STUDENT NAME: _____ STUDENT ID: _____

The above-named student has disclosed to the College of Nursing & Health Sciences that they have a medical, emotional, physical or psychological condition that may affect their ability to undertake professional practice. This capacity assessment will assist the academic team to identify if a suitable placement can be secured for the student.

To be completed by the student's usual treating doctor:

Physical Function – select applicable (blank fields indicate that limitations are not applicable)

	Can	Modifications	Cannot
Sit	☐	☐	☐
Stand/Walk	☐	☐	☐
Bend	☐	☐	☐
Squat	☐	☐	☐
Kneel	☐	☐	☐
Reach above shoulder	☐	☐	☐
Use injured arm/hand	☐	☐	☐
Lift	☐	☐	☐
Neck movement	☐	☐	☐

Physical Function – Additional Comments *e.g. limits on duration, weight capacity, movements or forces*

Mental Health Function - select applicable (blank fields indicate that limitations are not applicable)

	Not Affected	Affected
Attention/Concentration	☐	☐
Memory *(short and/or long term)*	☐	☐
Judgement (*ability to make decisions*	☐	☐

Mental Health Function – Additional Comments *e.g. cognitive function, effects of mental health function*

Based on the physical function assessment, any concerns for the student to undertake professional practice? ☐Yes ☐No

If yes please describe: -

Based on the mental health function assessment, any concerns for the student to undertake professional practice? ☐Yes ☐No

If yes please describe: -

Are there any special equipment/resources that could be provided to assist this student to undertake activities while on professional practice? ☐Yes ☐No

Do you believe this student is capable both physically and mentally to undertake professional practice at this time? Yes ☐ No ☐

If No, when do you believe they will be able to undertake professional practice?

Dr's Name: _____ **Provider Number:** _____

Signature: _____ **Date:** _____

Practice Stamp or Address Here