FORM
FITNESS FOR CLINICAL PRACTICE

Student name………………………………………………………………Student ID number………………

Type of incapacity…………………………………………………………………………………………

Period of time for restriction: from……………………………………to…………………………

Please complete the following details of this student’s capacity to engage in experiential clinical
learning in a hospital ward or community care.

Does the student have the ability to:

Move things/others frequently Yes/No 5kgs, 10kgs, 15kgs, 20kgs (please circle)
Transfer things/others frequently Yes/No 5kgs, 10kgs, 15kgs, 20kgs (please circle)
Push/pull trolleys Yes/No 5kgs, 10kgs, 15kgs, 20kgs (please circle)
Stand for a period of time Yes/No 10, 20, 40, 60 minutes or longer (please circle)
Sit for a period of time Yes/No 10, 20, 40, 60 minutes or longer (please circle)
Walk for a period of time Yes/No 10, 20, 40, 60 minutes or longer (please circle)
Climb stairs Yes/No
Kneel Yes/No
Squat Yes/No
Work above shoulder height Yes/No
Work below knee height Yes/No
Perform one handed duties/tasks Yes/No Right/Left (please circle)
Alternate between different tasks/duties 30 mins, 1hr, 2hr, 3hr (please circle)
Attend the clinical area for experience 1, 2, 3, 4, 5 days per week
Stagger times for attending clinical for stamina Yes/No (attend clinical for progressively longer
times each week)
Work with confused clients Yes/No
Participate in a rapidly changing workplace (eg: Accident and Emergency) Yes/No
Work in an area where sources of conflict occur (eg: mental health/counselling) Yes/No
Is there any special equipment/resources that could be provided to assist student learning Yes/No …please specify

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Form
Fitness for Clinical Practice (Cont’d)

Any other recommendations

Treating practitioner’s name: ___________________________ Date: __________

Contact number: ______________________________