Occupational Fitness Assessment Form

Section A: WORKER'S INFORMATION (completed by employee)

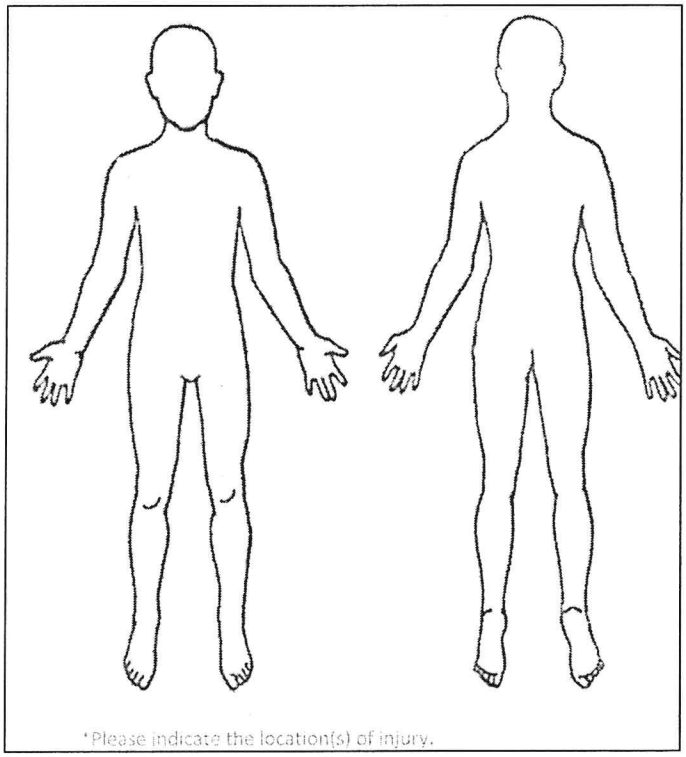
Employee's Surname	First Name	☐ Occupational ☐ Non-Occupational	Date of Injury / Illness	Employee Number
Physician's Name: Tel. No. ( ) - Fax. No. ( ) -			Today's Date	
Claim information:	☐ *ICBC*	☐ *WCB*	☐ *Other*	☐ *No claim/application for claim*

It is the intention to assist our employees to safely return to their regular duties as soon as medically practical. In doing so, we are able to offer the employee jobs that match their medical restrictions. The following will assist in this process.

Section B: FUNCTIONAL ABILITIES (check only those that apply)

Job Demands	Not capable of	Comments
STRENGTH	☐	
Lifting/Carry	☐	
Push/Pull >10lbs	☐	
Supporting Body Weight	☐	
Gripping/Handling (8 hours)	☐	
POSTURE/MOBILITY		**Comments**
Sitting for 8 hours	☐	
Driving for 8 hours	☐	
Standing for 8 hours	☐	
Walking for 8 hours	☐	
Bending/Stooping	☐	
Sustained Crouching/Kneeling	☐	
Climbing Stairs		
Climbing Ladders		**Comments**
Crawling	☐	
Balancing	☐	
Throwing	☐	
Overhead Reach	☐	
ENVIRONMENT		
Exposure to Elements	☐	
Uneven Surfaces	☐	
Proximity to moving objects	☐	
Vibration (upper extremity)	☐	
Vibration (whole body)		**Comments**

Section C : PLACE OF INJURY



*Please indicate the location(s) of injury.

Allergies

☐ Allergies: _____

☐ Can the identified allergy be prevented if a respirator is worn? _____

Ability to Drive

Is the patient able to drive in a safe manner? ☐ Yes ☐ No _____

Is the patient able to operate heavy equipment in a safe manner? ☐ Yes ☐ No _____

Cognitive/Mental Limitations

Does the patient's cognitive function affect their ability to perform the duties of their job in safe manner? Comment: _____

D Normal functional abilities may resume in: 1-7 days 8-14 days Specify:

Employees' not medically fit for regular duties; will require periodic reassessments for effective rehabilitation.

Scheduled reassessment date for:

This authorizes my attending physician to provide the information requested above to ILWU/BCMEA	Employee's Signature:	Date:

E Physician's name & address:	Physician's Signature:
	Physician's Telephone No:
	Date: