PLEASE NOTE: OFA forms are accepted on Wednesday from 9-11 am in the Local 500 Office. Forms will not be accepted outside of these hours.

# Occupational Fitness Assessment Form

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

| Employee's Surname: | First Name: | Employee Number: | Today's Date: |
|---|---|---|---|
| | | | |

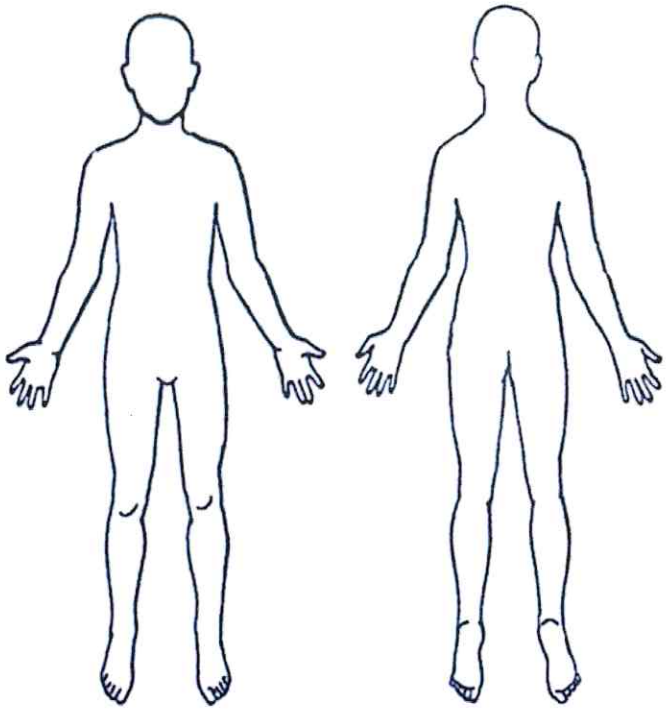
| Date of Injury / Illness: | Type of Injury / Illness: ☐ Occupational ☐ Non-Occupational | Claim Number: | Claim registered with: ☐ ICBC ☐ WCB ☐ Other_____ ☐ No claim/application for claim |
|---|---|---|---|
| | | | |

*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** | | |
| 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 | ☐ | |
| Crawling | ☐ | |
| Balancing | ☐ | |
| Throwing | ☐ | |
| Overhead Reach | ☐ | |
| **ENVIRONMENT** | | |
| Exposure to Elements | ☐ | |
| Uneven Surfaces | ☐ | |
| Proximity to moving objects | ☐ | |
| Vibration (upper extremity) | ☐ | |
| Vibration (whole body) | ☐ | |

## Section C: PLACE OF INJURY
(Please indicate the location(s) of injury)



**ALLERGIES**

List any allergies:

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

**ABILITY TO DRIVE**

Is the patient able to drive in a safe manner? ☐ Y ☐ N

Comments:

Is the patient able to operate heavy equipment in a safe manner? ☐ Y ☐ N

Comments:

**COGNITIVE/MENTAL LIMITATIONS**

Does the patient's cognitive function affect their ability to perform the duties of their job in safe manner? ☐ Y ☐ N

**Comments:**

## Section D: RETURN TO WORK

Normal functional abilities may resume in: ☐ 1-7 days ☐ 8-14 days Other (Specify):

| Employee is not medically fit for regular duties; will require periodic reassessments for effective rehabilitation. ☐ | **Scheduled Reassessment date for:** |
|---|---|
| | |

## Section E: PHYSICIAN'S NAME & ADDRESS

Physician's Stamp:

**This authorizes my attending physician to provide the information requested above to ILWU/BCMEA.**

| Employee's Signature: | Date: |
|---|---|
| | |

| Physician's Signature: | Date: |
|---|---|
| | |

Physician's Telephone Number:

**NOTE: THIS FORM WILL NOT BE ACCEPTED UNLESS STAMPED AND SIGNED BY CONSULTING PHYSICIAN**