Occupational Fitness Assessment Form

IN ORDER FOR YOUR REQUEST TO BE REVIEWED BY THE COMMITTEE, YOUR PHYSICIAN MUST ALSO PROVIDE A DETAILED RESPONSE TO THE QUESTIONS ON THE BACK OF THIS DOCUMENT (SECTION F)

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

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

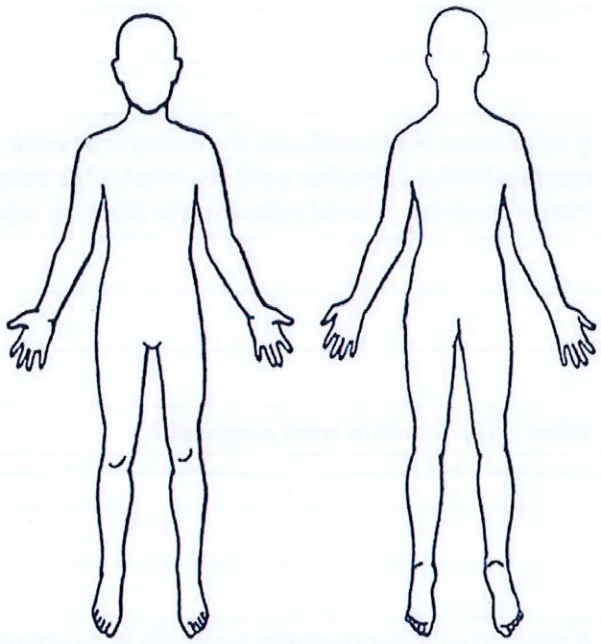
Date of Injury / Illness:	Type of Injury / Illness: ☐ Occupational ☐ Non-Occupational	Claim Number:	Claim registered with: ICBC ☐ WCB ☐ Other_____ ☐ No claim/application for claim

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 a 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

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Section F: Medical Profile Questionnaire

1. *Is this person medically fit to attend at work on a full-time basis? If not, when do you estimate this person will be fit to return to work?*

2. *Is this person currently medically fit to perform all of the employment duties and responsibilities of his/her position? If applicable, please review and reference the enclosed Job Demands Analysis (JDA) in your response.*

3. *If this person is not medically fit to attend at work on a full-time basis and/or perform the duties and responsibilities of his/her position, what is the nature of the medical condition impacting his/her ability to do so? Please state the general nature of the illness or injury (please do not provide a specific diagnosis).*

4. *What is the return to work prognosis?*

5. *If this person is not currently medically fit to attend at work on a full-time basis and/or perform all of the employment duties and responsibilities of his/her position, will this person ever be able to return full-time and to full-duties, and if so, when?*

6. *Does this person pose a risk to his/her own safety or the safety of others in the workplace?*	☐ Y ☐ N
7. *Course of Treatment:*	
a. *Has a course of treatment been prescribed or recommended for this person to follow related to this illness/injury?*	☐ Y ☐ N
b. *If a course of treatment has been prescribed or recommended, has this person followed the prescribed or recommended course of treatment?*	☐ Y ☐ N
c. *Has this person been referred to a medical specialist?*	☐ Y ☐ N

8. *What medical follow-ups, if any, are occurring?*