Occupational Health Assessment Form
Administrative Procedure 2.A.07A

TO ALL EMPLOYEES:

Please return this completed form to your supervisor within 24 hours of being away from work due to accident or serious illness, and/or prior to the start of your next scheduled shift.

A. To be completed by the employer and/or worker	
Worker's Last Name:	First Name:
Phone Number:	Date of Birth:
Address:	
Date of Accident/Illness:	
Employer Address: Box 1200, Gimli, MB R0C 1B0	
Employer Contact Name and Title: Cara Desimpelaere, Human Resources Officer	
Employer Telephone: 204-642-6260	
Employer Fax: 204-642-7273	
1. Type of job at time of accident (attach job description):	
2. Areas of Injury(ies)/Illness(es):	
3. Potential Employment Hazards: ☐ Explosives ☐ Electric Shock Radiation ☐ Ionizing, ☐ Non-ionizing ☐ Falling Objects ☐ Sharp Objects ☐ High, exposed places ☐ Sustained posture ☐ Intermittent noise ☐ Continuous noise ☐ Awkward posture ☐ Moving mechanical parts ☐ Physical Violence ☐ Infectious exposure ☐ Waste handling ☐ Repetitive movements ☐ Biological/Chemical Contaminants ☐ Other: _____	

B. Worker's Signature
By signing below, I am authorizing any health professional who treats me to provide me and my employer with information about my functional/physical abilities
Signature:
Date:

Occupational Health Assessment Form
Administrative Procedure 2.A.07A

C. Health Professional Information
☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse ☐ Other
Health Professional's Name (please print)
Address:
I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation.
Health Professional's Signature:
Date:
Telephone Number:

D. The following information should be completed by the Health Professional to identify the patient's overall abilities and restrictions.
Date of Assessment:
Please check one: ☐ Patient is capable of return to work with **no restrictions**. ☐ Patient is capable of returning to work **with restrictions**. Complete section E and F. ☐ Patient is physically unable to return to work at this time. Complete section F.

E. Abilities and/or Restrictions			
1. Please indicate **Abilities** that apply. Include additional details in section 3.			
Walking: ☐ Full abilities ☐ Up to 100 metres ☐ 100-200 meters ☐ Other (please specify)	Standing: ☐ Full abilities ☐ Up to 15 minutes ☐ 15-30 minutes ☐ Other (please specify)	Sitting: ☐ Full abilities ☐ Up to 30 minutes ☐ 30 minutes – 1 hour ☐ Other (please specify)	Lifting from floor to waist: ☐ Full abilities ☐ Up to 5 kgs ☐ 5 – 10 kgs ☐ Other (please specify)
Lifting from waist to shoulder: ☐ Full abilities ☐ Up to 5 kgs ☐ 5 – 10 kgs ☐ Other (please specify)	Stair Climbing: ☐ Full abilities ☐ Up to 5 steps ☐ 5 – 10 steps ☐ Other (please specify)	Ladder Climbing: ☐ Full abilities ☐ 1 – 3 steps ☐ 3 – 6 steps ☐ Other (please specify)	Ability to Drive a Motor Vehicle: ☐ Yes ☐ No

Occupational Health Assessment Form
Administrative Procedure 2.A.07A

<table>
<tr><td colspan="4">2. Please indicate Restrictions that apply. Include additional details in Section 3</td></tr>
<tr><td>☐ Bending/twisting repetitive movement of (please specify)</td><td>☐ Work at or above shoulder activity:</td><td>☐ Chemical exposure to:</td><td>☐ Environmental exposure to: (eg. Heat, cold, noise, scents)</td></tr>
<tr><td colspan="2">☐ Limited use of hand(s)
Left — Right
☐ Gripping ☐
☐ Pinching ☐
☐ Other (specify) ☐</td><td>☐ Limited pushing/pulling with:
☐ Left arm
☐ Right arm
☐ Other (specify)</td><td>☐ Operating motorized equipment: (e.g. floor scrubber)</td></tr>
<tr><td colspan="2">☐ Potential side effects from medication (please specify). Do not include names of medications.</td><td colspan="2">☐ Exposure to vibration:
☐ Whole body
☐ Hand/Arm</td></tr>
<tr><td colspan="4">3. Additional Comments on Abilities and/or Restrictions.</td></tr>
<tr><td colspan="4">4. From the date of this assessment, the above will apply for approximately:
☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 14+ days</td></tr>
<tr><td colspan="4">5. Have you discussed return to work with your patient? ☐ yes ☐ no</td></tr>
<tr><td colspan="4">6. Recommendations for work hours and start date:
☐ Regular full-time hours ☐ Modified hours ☐ Graduated hours
Start Date:</td></tr>
</table>

F. Date of Next Appointment
Recommended date of next appointment to review **Abilities and/or Restrictions:**