# Occupational Fitness Assessment

## A

**Supervisor**

| Employee's Surname | First Name | SIN | Shift |
|---|---|---|---|
| | | | |

| Department | Employee's Job Title |
|---|---|
| | |
| Supervisor's Name | Supervisor's Tel. No. ( ) - |
| | |

☐ Injury on Duty ☐ Illness

| Date of Injury/Illness Y M D | 1st Day Absent Y M D |
|---|---|
| | |

## B Assessment

Due to injury or illness this employee has

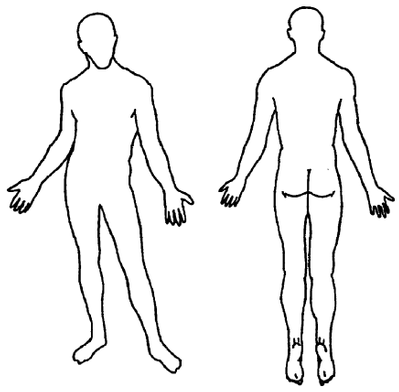
☐ Normal Functional Abilities *(Fit for Regular Duties)* (No additional information needed. Please sign section E)

☐ Reduced Functional Abilities (Please complete Sections C,D & E)

**Physician**

## C Functional Abilities: ( If unable to test, please estimate)

**Step 1** Please circle the appropriate letter(s) & body area(s) to indicate the affected area(s)



- **A** Systemic or Non-Physical
- **B** Head *(incl. vision, hearing, speech)*
- **C** Neck
- **D** Upper back, chest,upper abdomen
- **E** Lower back
- **F** Lower abdomen
- **G** Shoulder or upper arm
- **H** Elbow or lower arm
- **I** Wrist or hand
- **J** Hip or upper leg
- **K** Knee or lower leg
- **L** Ankle or foot
- **M** Respiratory/Aerobic

| **Step 2** Please indicate reduced abilities | **Step 3** Please indicate extent of abilities | | |
|---|---|---|---|
| **Walk** | Maximum Duration*(hours)*: 1 2 4 5+ other<br>☐ Short distances only ☐ No walking | | |
| **Stand** | Maximum Duration*(hours)*: 1 2 4 5+ other | | |
| **Sit** | Maximum Duration*(hours)*: 1 2 4 5+ other | | |
| **Lift/Carry** | **Occasionally** | **Weight** *(kg)* | **Less than 9kg - Specify** |
| floor - waist | | 21 16 9 | |
| waist - shoulder | | 21 16 9 | |
| above shoulder | | 21 16 9 | |
| **Bend/Twist** | **Occasionally** | **Not at all** | **Specify** |
| neck | | | |
| back | | | |
| **Push/Pull** | **Occasionally** | **Not at all** | **Specify** |
| moderate load | | | |
| light load | | | |
| **Climb** | **Occasionally** | **Not at all** | **Specify** |
| flight of stairs | | | |
| few steps | | | |
| **Reach** | **Occasionally** | **Not at all** | **Specify** |
| above shoulder | L R | L R | |
| below shoulder | L R | L R | |
| **Use Hands For:** | **Occasionally** | **Not at all** | **Specify** |
| writing | L R | L R | |
| typing | L R | L R | |
| fine manipulation | L R | L R | |
| grasping | L R | L R | |
| **Sensory** | To See | To Hear | To Speak / To Maintain Balance |
| | Specify: | | |
| **Operate Equipment** | Specify: | | |
| **Hours of Work** | Specify: | | |
| **Other** | Specify: | | |

**Other Comments/Instructions (NO DIAGNOSIS OR TREATMENT)**

## D

The Airport Authority will strive to find transitional work to match the employee's functional abilities. The following information will assist in this process.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| This employee can begin work with the above noted abilities | ☐ Immediately | After 1 2 3 4 *(Days)* | other: | | | | | |
| Normal functional abilities may resume in ..... | 1-3 days | 4-7 days | 8-14 days | 15-28 days | 1-2 months | 2-3 months | over 3 months | specify: |
| Note: *Employees not medically fit for regular duties will require periodic reassessments for effective rehabilitation.* | | | | | | | Scheduled reassessment for: Y M D | |

## E Physician's Name & Address

| place name & address here | Signature | |
|---|---|---|
| | Date Y M D | Telephone ( ) - |

**Detach here & process for payment** (white copy

## F Reimbursment Invoice:

To be reimbursed for the completion of this form, please fill out before returning this form.

**Invoice**

| Payee's Name and Address | Amount | GST | Total | GST Registration No. |
|---|---|---|---|---|
| place name & address here | ☐ Section E only $24.00 | $1.68 | $25.68 | |
| | ☐ Complete Form $37.50 | $2.63 | $40.13 | |
| | Employee Surname / First Name | | | Date Y M D |

Please return form to **Occupational Health & Safety,** Airport Authority, P.O. Box 23750. Richmond, B.C. V7B 1Y7

**White - OHS** **Yellow - Employee** **Pink - Physicia**