Occupational Fitness Assessment Form

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

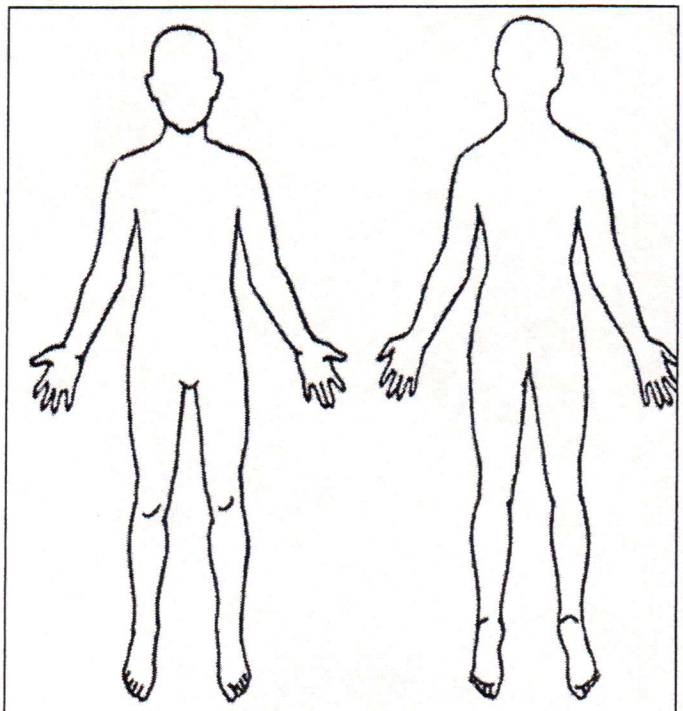
Employee's Surname	First Name	☐ Occupational ☐ Non-Occupational	Date of Injury / Illness	Employee Number
Physician's Name: Tel. No. ( ) - Fax. No. ( ) -			Today's Date	
Claim information:	☐ *ICBC*	☐ *WCB*	☐ *Other*	☐ *No claim/application for claim*

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 Function

Does the patient's cognitive function affect their ability to perform the duties of their job in safe manner? ☐ Yes ☐ No _____

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:

British Columbia Maritime Employers Association (the "BCMEA")
Occupational Fitness and Assessment Form

Dear Doctor:

The BCMEA administers the employment of Longshore workers for approximately seventy companies in waterfront operations in British Columbia. These employers include ship owners, container terminals, dry bulk, liquid bulk and break-bulk terminal operations and stevedoring.

Long Shore work is extremely variable and includes the Trades, heavy equipment operation, labouring and other assignments in a safety-sensitive work environment.

The BCMEA recognizes that often employees, through medical reasons, are unable to perform the full range of their regular duties. In these circumstances, we are committed to facilitating an early return to work and/or maintaining ongoing work opportunities that are within employees' medical limitations.

Please estimate this Longshore worker's current functional limitations and prognosis on the attached form in order to assist us in facilitating an early return to work and/or in maintaining ongoing work opportunities.

This completed form will be also provided to the direct employers represented by our Association. We request that you do not provide medically confidential information such as diagnosis or treatment.

The cost associated with the completion of this form will be borne by the worker.

Thank you.