UNIVERSITY OF SASKATCHEWAN
Safety Resources
SAFETYRESOURCES.USASK.CA

PHYSICAL ASSESSMENT

The injured worker is to return this form to their supervisor

WCB code 640

Patient's Name: _____ **WCB Claim #** (if known)**:** _____

Date of Birth: _____ **Date of Injury:** _____ **Last Date Worked:** _____

Nature of Injury: _____

Patient's Signature: X _____ **Date:** _____

The patient's signature gives consent to the healthcare provider to communicate the information below to Safety Resources.

PHYSICAL & MUSCULOSKELETAL FUNCTION

Please identify all restrictions and limitations currently affecting the patient's ability to work due to diagnosed medical condition(s).

☐ **Sitting** (includes driving)**:** maximum continuous duration _____ minutes
break duration _____ minutes, every _____ minutes
total duration/shift _____ hours

☐ **Standing/Walking:** maximum duration _____ minutes, distance _____feet

☐ **Balance:** special circumstances requiring good balance _____

☐ **Climbing:** stairs, maximum # _____ ladders, maximum height _____ feet

☐ **Working at Heights:** ☐ not safe ☐ maximum height _____ feet

☐ **Low-level Activity:** crouching, squatting, kneeling, crawling

☐ **Reaching:** ☐ left ☐ right ☐ forward ☐ overhead ☐ to side

☐ **Bending/Twisting:** ☐ neck ☐ trunk direction _____

☐ **Lifting:** ☐ floor to waist range, maximum weight _____ lbs.
☐ waist to shoulder range, maximum weight _____ lbs.
☐ above shoulder range, maximum weight _____ lbs.

☐ **Carrying:** ☐ left ☐ right maximum weight _____ lbs.

☐ **Gripping:** ☐ left ☐ right ☐ light ☐ heavy

☐ **Pushing/Pulling:** ☐ mobile ☐ static maximum weight _____ lbs.

☐ **Fine Dexterity Tasks:** (hands/fingers) keyboarding, precision work, fine manipulation
limited duration _____ minutes

☐ **Visual/Computer Work:** limited duration _____ minutes

☐ **Operating Motorized Equipment:** ☐ not safe ☐ limited duration _____ minutes

☐ **Mental/Emotional Limitations:** _____

☐ **Other:** _____

Comments/Other:

ACCOMMODATION/RETURN-TO-WORK PLAN RECOMMENDATIONS

Is this patient able to perform modified work? ☐ Yes ☐ No If yes, dates effective: _____

How many hours in a day are they able to work? _____ **Expected duration:** _____

Reassessment date, if required: _____ **Is a complete recovery expected?** ☐ Yes ☐ No ☐ Unknown

HEALTH CARE PROVIDER'S NAME & CONTACT INFORMATION: (print or stamp)

Date: _____

Signature: X _____

Safety Resources-WCB Support, 150 Research Annex, 105 Maintenance Road, University of Saskatchewan, Saskatoon SK, S7N 5C5
Email: wcb.support@usask.ca • **Tel: (306) 966-8707** • **Fax: (306) 966-8394**

LETTER TO PHYSICIAN

The University of Saskatchewan understands and supports our responsibility to returning injured workers to the workplace. We have a modified work program in place and can accommodate any work restrictions that may be necessary for the injured worker.

We request your assistance in identifying and recommending any temporary functional limitations your patient may have. This will assist us with providing the most suitable work accommodations during your patient's recovery.

Please complete the Physical Assessment form on the other side of this page and provide it to your patient prior to their departure from your office so they can return it to their supervisor.

If you have any questions and/or concerns, please contact us at (306) 966-8707.

Sincerely,
Safety Resources-WCB Support
University of Saskatchewan