INJURED WORKER ASSESSMENT (IWA)

The worker shall return this assessment to their supervisor immediately

To the Healthcare Provider: The University of Saskatchewan has a comprehensive return-to-work program that supports returning our workers to the workplace safely and effectively. To provide the most suitable work accommodations during their recovery we request your assistance in identifying below any temporary functional limitations they may have.

Patient Name: (print) _____ **Date of Birth:** _____

Nature of Injury: _____ **Date of Injury:** _____

PHYSICAL & MUSCULOSKELETAL FUNCTION

☐ **Sitting:** maximum continuous duration _____ min.
break duration _____ min., every _____ min.
total per shift _____ hr.

☐ **Driving Motorized Equipment/Vehicle:** ☐ not safe ☐ limited duration _____ min.

☐ **Standing/Walking:** max. duration _____ min., distance _____ ft.

☐ **Balance:** ☐ independent ☐ assisted ☐ impossible

☐ **Climbing:** ☐ stairs, max. # _____; ☐ ladders, max. height _____ ft.

☐ **Working at Heights:** ☐ not safe ☐ max. height _____ ft.

☐ **Low-level Work:** squatting ☐ yes ☐ no; kneeling ☐ yes ☐ no; crawling ☐ yes ☐ no

☐ **Pushing/Pulling:** ☐ mobile ☐ static max. weight _____ lb.

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

☐ **Bending/Twisting:** neck ☐ left ☐ right; trunk ☐ left ☐ right

☐ **Lifting:** ☐ floor to waist, max. weight _____ lb.
☐ waist to shoulder, max. weight _____ lb.
☐ above shoulder, max. weight _____ lb.

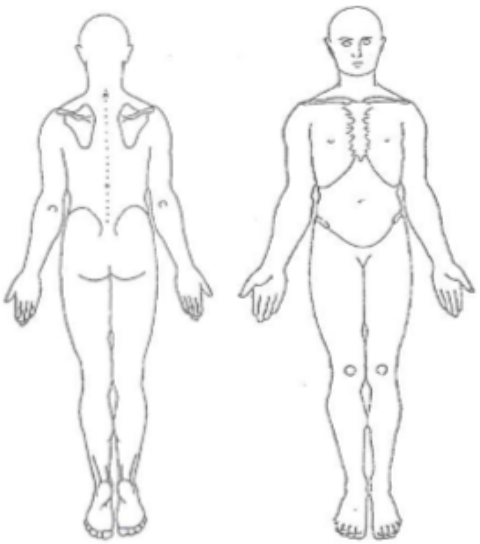
☐ **Carrying/Gripping:** ☐ left arm ☐ right arm ☐ both arms
☐ 0-5 lb. ☐ 5-10 lb. ☐ 10-20 lb. ☐ 20+ lb. ☐ other _____

☐ **Fine Dexterity:** (hands/fingers) keyboarding/precision work, duration _____ min.

☐ **Visual/Computer Work:** limited duration _____ min.

☐ **Psychological Limitations:** _____

Circle areas affected.



Comments:

ACCOMMODATION/RETURN-TO-WORK 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

HEALTHCARE PROVIDER NAME AND CONTACT INFORMATION: (print or stamp)

Bill this form to WCB Code 640

Date: _____

Signature: _____

UNIVERSITY OF SASKATCHEWAN

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MISSION: ZERO

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