

Forklift Driver

Initial work capacity form



Purpose of this form

This form is designed to be completed by injured workers and their supervisors and/or the return to work coordinator, if applicable;

- to determine the tasks the worker may be able to do with or without modifications, and
- to inform the medical practitioner what tasks the worker may be able to safely undertake.

The form lists a range of work tasks typically performed by a forklift driver where each task has been rated according to the impact on five body parts; **Green** for little or no impact, **Amber** for some impact or **Red** for significant impact.

Instructions for workers, supervisors and return to work coordinators

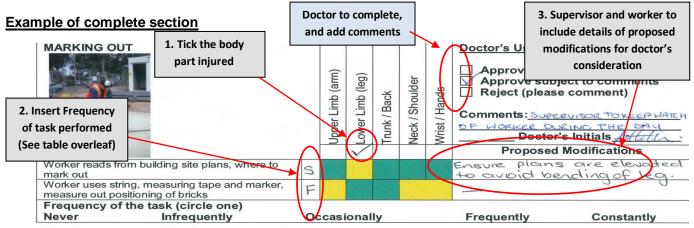
The injured worker and their supervisor (with their return to work coordinator, if appropriate) assess the work requirements using the following three steps to determine what duties may be suitable to perform.

- 1. Tick above the coloured column of the body part(s) affected by the injury.
- 2. For each task, determine the frequency that an employee usually performs the task using the table overleaf. In the "frequency" column, insert the letter code for the frequency of the task (see table overleaf for details).
- 3. Together review the duties performed and the worker's capacity and agree on options to accommodate the injury, taking into account those duties are coded Red and Amber for the injured body parts.

Once these steps have been followed for each task, initial each page, complete the declaration at the back and take it to the treating doctor for consideration and approval.

Instruction for medical practitioners

- Review the proposed work accommodations documented on this form that have been agreed to by the injured worker
 and their supervisor. These tasks have been evaluated by an Occupational Therapist to determine the impact on body
 parts when performing the duties.
- Indicate your level of support or not for each option; include comments where indicated and initial the relevant section.There is more space for comments on the last page of the document if required.
- 3. Complete the "Doctor Review" section on the last page and provide a copy for the worker.
- 4. Please note: the worker will still require a WorkCover medical certificate



What sort of accommodations can be made?

The supervisor and worker are well placed to consider what duties may be suitable and what accommodations could assist the return to work process. However, options need to be safe to perform and not aggravate the injury and must have confirmation of the treating doctor.

Examples of accommodations are:

- ☑ Provide assistance for certain tasks
- ☑ Reduced work hours for a short period of time
- Avoid certain tasks for a short period of time
- Modify tasks to make them easier
- ✓ Use equipment to reduce the load



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| EMPLOYER: | | |
|-----------|------|--|
| EMPLOYEE: | | |

NOTE: When completing the tables below, use the following table as a guide to frequency of performing a task.

| | Code | Non-Material Handling | Non-Material Handling | Material Handling |
|------------|------|------------------------------|-----------------------------|----------------------------|
| Never | N | 0% of an 8hr working day | No Repetitions per day | No Repetitions per day |
| Rarely | R | 1-5% of an 8hr working day | 1-2 Repetitions per day | 1-2 Repetitions per day |
| Sometimes | S | 6-33% of an 8hr working day | 3-100 Repetitions per day | 3-32 Repetitions per day |
| Frequently | F | 34-66% of an 8hr working day | 101-800 Repetitions per day | 33-200 Repetitions per day |
| Constantly | С | 67-100% of an 8hr work day | >800 Repetitions per day | >200 Repetitions per day |

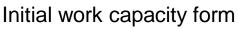
| GREEN | Little impact or no impact on the body part, generally able to perform these duties |
|-------|---|
| AMBER | Some impact on the body part, consider modifications to minimise exposure |
| RED | May have significant impact on the body part, exercise caution with these duties |

| USING A VEHICLE | Frequency | Upper Limb (arm) | Lower Limb (leg) | Trunk / Back | Neck / Shoulder | Wrist / Hands | Doctor's Use Only: Approve Approve subject to comments Reject (please comment) Comments: Doctor's Initials Proposed Modifications |
|---|-----------|------------------|------------------|--------------|-----------------|---------------|---|
| Worker drives vehicle to / from site. | | | | | | | |
| Steering and operation of gears [if applicable] | | | | | | | |
| Operating foot controls | | | | | | | |

| CLIMBING INTO THE FORKLIFT | Frequency | Upper Limb | Lower Limb | Trunk / Back | Neck / Shoulder | Wrist / Hands | Doctor's Use Only: Approve Approve subject to comments Reject (please comment) Comments: Doctor's Initials |
|---|-----------|------------|------------|--------------|-----------------|---------------|---|
| | | | | | | | Proposed Modifications |
| Driver pulls self into forklift with aid of handles | | | | | | | |
| Driver performs the pre-start check of forklift | | | | | | | |



Forklift Driver





| DRIVING | | Upper Limb | Lower Limb | Trunk / Back | Neck / Shoulder | Wrist / Hands | Doctor's Use Only: Approve Approve subject to comments Reject (please comment) Comments: Doctor's Initials |
|--|--|------------|------------|--------------|-----------------|---------------|---|
| | | | | | | | Proposed Modifications |
| Driver looks over left and right shoulders, checking | | | | | | | |
| blind spots | | | | | | | |
| Exposure to whole body vibration | | <u></u> | | | , | | |
| Driver operates both foot pedals | | | | | | | |
| Driver operates levers with both right and left hands and with a light push/pull force | | | | | | | |

| OTHER Provota | Frequency | Upper Limb | Lower Limb | Trunk / Back | Neck / Shoulder | _ | Doctor's Use Only: Approve Approve subject to comments Reject (please comment) Comments: Doctor's Initials Proposed Modifications |
|--|-----------|------------|------------|--------------|-----------------|---|--|
| Refill gas bottle on back of forklift [sometimes required to be pulled off cradle – weighs up to 34kg when full] | | | | | | | |
| Driver may be required to manually handle or shift load when required | | | · | | | | |



Company Name

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WORKERS & SUPERVISORS DECLARATION

We have reviewed and considered what available work can be safely and reasonably performed and what accommodations can be included. We have undertaken this in good faith and with a view to accommodating the injury and maximising the range of duties that can safely and reasonably be performed, and seeking a successful return to preinjury duties.

| Company Namo | Worker's signature | Supervisors signature |
|--|--|----------------------------------|
| | Workers name | Supervisors name |
| | Date | Date |
| DOCTOR'S REVIEW | | |
| Additional comments: (If none, please write "N | /A") | |
| | | |
| | | |
| I have reviewed the proposed work modification is able to perform the proposed duties. | ons and confirm that in my view, subject | to my comments above, the worker |
| These duties should be reassessed on | (date) | |
| (signed) | | |

For information and assistance on completing this form members of Master Builders may contact Houda Peters at Master Builders on (08) 8211 7466

Disclaimer

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