

# 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

1. 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.
2. 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

### Example of complete section

**MARKING OUT**



**2. Insert Frequency of task performed (See table overleaf)**

**1. Tick the body part injured**

	Upper Limb (arm)	Lower Limb (leg)	Trunk / Back	Neck / Shoulder	Wrist / Hands
Worker reads from building site plans, where to mark out	S				
Worker uses string, measuring tape and marker, measure out positioning of bricks	F				

**Frequency of the task (circle one)**

Never      Infrequently      Occasionally      Frequently      Constantly

**Doctor to complete, and add comments**

**3. Supervisor and worker to include details of proposed modifications for doctor's consideration**

**Doctor's Use**

☐ Approve

☒ Approve subject to comments

☐ Reject (please comment)

**Comments:** SUPERVISOR TO KEEP WATCH OF WORKER DURING THE DAY

**Doctor's Initials:** [Signature]

**Proposed Modifications:** Ensure plans are elevated to avoid bending of leg.

### 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:

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Provide assistance for certain tasks           | <input checked="" type="checkbox"/> Modify tasks to make them easier |
| <input checked="" type="checkbox"/> Reduced work hours for a short period of time  | <input checked="" type="checkbox"/> Use equipment to reduce the load |
| <input checked="" type="checkbox"/> Avoid certain tasks for a short period of time |  |

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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	<b>N</b>	0% of an 8hr working day	No Repetitions per day	No Repetitions per day
Rarely	<b>R</b>	1-5% of an 8hr working day	1-2 Repetitions per day	1-2 Repetitions per day
Sometimes	<b>S</b>	6-33% of an 8hr working day	3-100 Repetitions per day	3-32 Repetitions per day
Frequently	<b>F</b>	34-66% of an 8hr working day	101-800 Repetitions per day	33-200 Repetitions per day
Constantly	<b>C</b>	67-100% of an 8hr work day	>800 Repetitions per day	>200 Repetitions per day

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

USING A VEHICLE							Doctor's Use Only:	
	Frequency	Upper Limb (arm)	Lower Limb (leg)	Trunk / Back	Neck / Shoulder	Wrist / Hands		
								
Worker drives vehicle to / from site.								
Steering and operation of gears [if applicable]								
Operating foot controls								

CLIMBING INTO THE FORKLIFT							Doctor's Use Only:	
	Frequency	Upper Limb	Lower Limb	Trunk / Back	Neck / Shoulder	Wrist / Hands		
								
Driver pulls self into forklift with aid of handles								
Driver performs the pre-start check of forklift								

OTHER	Frequency	Upper Limb	Lower Limb	Trunk / Back	Neck / Shoulder	Wrist / Hands	Doctor's Use Only:
							<input type="checkbox"/> Approve <input type="checkbox"/> Approve subject to comments <input type="checkbox"/> 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							

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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 pre-injury duties.

Company Name .....

Worker's signature

Supervisors signature

Workers name

Supervisors name

Date

Date

### DOCTOR'S REVIEW

Additional comments: (If none, please write "N/A")

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.....

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.....

.....

I have reviewed the proposed work modifications and confirm that in my view, subject to my comments above, the worker is able to perform the proposed duties.

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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