

Steel Fixer

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 steel fixer 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 and/or return to work coordinator, if applicable, assess the work requirements and what duties may be suitable to perform by using the following three steps:

Step 1: Tick above the coloured column of the body part(s) affected by the injury.

Step 2: To the right of each task listed, insert the letter code that represents the frequency of the task (see the frequency table on the next page for the letter codes)

Step 3: Together review the duties performed, the worker's capacity and agree on options to accommodate the injury, taking into account those duties that are coded **Red** and **Amber**.

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 in this form as agreed 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 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.
- Complete the "Doctor Review" section on the last page and provide a copy for the worker.
- NB:** 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:

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

Steel Fixer

Initial work capacity form

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	C	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								

LOADING/UNLOADING EQUIPMENT		Frequency	Upper Limb (arm)	Lower Limb (leg)	Trunk / Back	Neck/Shoulders	Wrist / Hands	Doctor's Use Only:
								☐ Approve ☐ Approve subject to comments ☐ Reject (please comment) Comments: _____ Doctor's Initials _____ Proposed Modifications _____
Carrying materials onsite [up to 25kg]								
Climbing onto back of trucks								

Steel Fixer

Initial work capacity form

FIXING STEEL		Frequency	Upper Limb (arm)	Lower Limb (leg)	Trunk / Back	Neck/Shoulders	Wrist / Hands	Doctor's Use Only: ☐ Approve ☐ Approve subject to comments ☐ Reject (please comment) Comments: _____ Doctor's Initials _____
								Proposed Modifications
Using hand tools			Yellow	Green	Yellow	Yellow	Yellow	
Using power tools			Yellow	Green	Yellow	Yellow	Yellow	
Negotiating uneven grounds			Green	Red	Yellow	Green	Green	
Supporting fixtures in position			Yellow	Yellow	Yellow	Yellow	Yellow	

Steel Fixer

Initial work capacity form

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	 Supervisor's signature
	 Workers name	 Supervisors name
	 Date	 Date

DOCTOR'S REVIEW

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

.....
.....
.....
.....
.....

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

This document is prepared by the Master Builders Association of South Australia, Inc (Master Builders) as a service for building industry participants to assist in managing the return to work of injured workers. It is not a substitute for professional health advice, nor is it intended to be used to diagnose, treat, cure or prevent any injury, disease or condition. You should not take any action or change your current treatment without consulting and obtaining approval from qualified health care professional. The accuracy, currency and completeness of the information available in this documentation cannot be guaranteed. All industry participants have obligations under workplace health and safety laws in relation to their workers. This document is not a substitute for a risk assessment and its use does not ensure compliance with health and safety obligations. Master Builders recommend that industry participants obtain professional advice in relation to all safety matters. Master Builders, its affiliates and their respective servants and agents do not accept any liability for any injury, loss or damage incurred by the use of or reliance on this document, whether arising from negligence or otherwise. © 2013 Master Builders Association of South Australia Inc and WorkCover SA.