Early Medical Assessment



Domestic Appliance Retailing

Air Conditioning Stores/Warehouse

1. Domestic Appliance Retailing
2. Air Conditioning Stores/Warehouse

Dear Doctor: This form will take up to 5 minutes to complete. Please review each task the worker undertakes (both picture and written description) and tick whether or not the worker can complete this task. If modification required, please leave comments. Space at the end of this document is available for final comments and recommendations.

|  |  |  |
| --- | --- | --- |
| IMGP3254IMGP3253 | **Manual Handling*** Occasional maneuvering and lifting of items greater than 55kg.
* Frequent rolling of gas bottles, requiring claw grasping and internal/external shoulder movements.
* Frequent handling of plant/equipment.
* Frequent handling of small parts.
* Frequent handling of air-conditioning units requiring bilateral gross claw and flat palmer grasping as well as some lumbar twisting.
 | Doctor Approval[ ]  Yes [ ]  NoComments: |
| IMGP3240 | **Forklift Driving*** Bilateral upper and lower limb coordination to operate the foot and hand controls when in operation.
* Frequent cervical neck flexion, extension and rotation.
* Occasional thoracic lumbar twisting to view behind forklift when reversing.
 | Doctor Approval[ ]  Yes [ ]  NoComments: |
| IMGP3250 | **Physical Requirements*** Occasional stair climbing is required involving bilateral lower limbs.
* Accessing items from floor to above head heights requiring squatting/kneeling, lumbar stooping and overhead reaching with shoulders flexed to greater than 160°.
 | Doctor Approval[ ]  Yes [ ]  NoComments: |

1. Work Capacity Form

**Doctor Review (include final comments)**

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I confirm that in my view, subject to the above comments, the worker is able to perform certain duties detailed in this Early Medical Assessment.

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| --- | --- | --- |
| These duties should be reassessed on: |  | Date: |

|  |  |  |
| --- | --- | --- |
| Signature : |  | Date: |

**Employers Declaration:**

I confirm that I/we have reviewed the Doctor’s recommendations and comments. I/we will make suitable changes to make allowances for the Dr’s recommendations.

|  |  |  |
| --- | --- | --- |
| Signature : |  | Date: |

**Employees Declaration**

My Doctor has discussed their recommendations with me. I have been given the opportunity to participate in this process.

|  |  |  |
| --- | --- | --- |
| Signature : |  | Date: |

For information on completing this form, please contact Business SA on 08 8300 0000.

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