Early Medical Assessment

Domestic Hardware and

Homeware Retailing

Key Cutter

Domestic Hardware and Homeware Retailing

Key Cutter

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.

|  |  |  |
| --- | --- | --- |
| photo.JPGphoto3.JPG | **Stock Handling*** Accessing small items (keys) from hooks requiring some light stooping and light overhead reaching
* Occasional acceptance of deliveries and light parcels up to 10kg
* Firm wrist and slight shoulder movements required for operating knobs on key cutting machinery
* Frequent accessing of light items from drawers and shelving requiring bending and occasional squatting
 | Doctor Approval[ ]  Yes [ ]  NoComments: |
| photo 1.JPG | **Customer Service*** Standing and discussing product
* Handling stock (keys only) from wall hangers
* Standing at front counter
* Occasional writing
* Bilaterally grasping items
* Handling cash or EFT
 | Doctor Approval[ ]  Yes [ ]  NoComments:  |
| photo2.JPG | **Key Cutting Duties*** Frequent handling of small parts (e.g. keys)
* Applying a firm wrist and slight movement of the shoulder to operate knobs on key cutting machinery
* Standing position at working bench with some light stooping required to operate machinery
* Key cutting with the use of both hearing and eye protection
 | Doctor Approval[ ]  Yes [ ]  NoComments: |

1. Work Capacity Form

**Doctor Review (include final comments)**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

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.

|  |  |  |
| --- | --- | --- |
| 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 Doctor’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.

***Disclaimer:*** *This document is published by Business SA with funding from ReturnToWorkSA. All workplaces and circumstances are different and this document should be used as a guide only. It is not diagnostic and should not replace consultation, evaluation, or personal services including examination and an agreed course of action by a licensed practitioner. Business SA and ReturnToWorkSA and their affiliates and their respective agents do not accept any liability for injury, loss or damage arising from the use or reliance on this document. The copyright owner provides permission to reproduce and adapt this document for the purposes indicated and to tailor it (as intended) for individual circumstances*. (C) 2016 ReturnToWorkSA