This form records the findings and outcomes of the standalone workplace assessment.

Please send a copy to the ACC contact person.

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| 1. Client details | |
| Client name: | Claim number: |
| Date of injury: | |

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| 2. Contact details | |
| Lead supplier company name: | Lead supplier contact person: |
| Treatment provider company name: | |
| Treatment provider name: | Treatment provider email address: |
| ACC contact name: | ACC contact person email address: |

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| 3. Assessment details | | | |
| Date assessment completed: | Did you visit the work site? | Yes | No |
| If no, please advise why: | | | |

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| 4. Work situation | | |
| Nature of business: | Employment start date: | |
| Current:  Yes  No | Finish date (where applicable): | |
| Work hours and days: | Client’s job title: | |
| If shift work applies please provide details: | | |
| Location of where the client normally works: | | Manager’s name: |
| Provide an overview of the work situation: | | |

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| 5. Functional job tasks | | | |
| Complete the following table to let us know how well this client can perform their work duties. | | | |
| Name of normal work task and % of time spent on it | Physical requirements | | |
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| Please identify any impacts due to the injury and if this can be overcome by modification or use of equipment: | | | |
| If equipment is required, can you source this: | | Yes | No |
| If yes, please advise the approximate cost: | | | |
| If no, please provide details of the equipment that is needed: | | | |
| List the work options or actions that you have identified during the site visit to support this client’s early recovery at work, eg light duties, alternative duties: | | | |
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| 6. Typical physical and mental demands | | |
| Type of Demand | Frequency | Comments |
| Lifting |  |  |
| Carrying |  |  |
| Pushing / Pulling |  |  |
| Sitting |  |  |
| Standing |  |  |
| Walking |  |  |
| Reaching |  |  |
| Kneeling |  |  |
| Bending |  |  |
| Squatting / Crouching |  |  |
| Twisting |  |  |
| Stairs |  |  |
| Mental / Cognitive |  |  |
| Other: Climbing, Crawling |  |  |
| Sensory activities |  |  |
| Overall physical demand level: |  | |
| NOTE: Occasionally – up to one third of the day, Frequently – one to two thirds of the day, Constantly – above two thirds of the day | | |

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| 7. Workplace environment |
| What is this client’s work environment like? |
| Outline and specific equipment or tools operated or used: |
| Comment on any other identified demands of the workplace not already outlined eg psychosocial, cultural environmental: |

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| 8. Provider declaration and signature | |
| I declare the information provided by me on this form is, to the best of my knowledge, accurate and complete. | |
| Provider name: | |
| Signature: | Date: |

When we collect, use and store information, we comply with the Privacy Act 2020 and the Health Information Privacy Code 2020. For further details see ACC’s privacy policy, available at [www.acc.co.nz](https://aus01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.acc.co.nz%2F&data=04%7C01%7CSonia.DeLautour%40acc.co.nz%7Cf3a57126063245d3c61608d8708c27c8%7C8506768fa7d1475b901cfc1c222f496a%7C0%7C0%7C637383094545478020%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=2AC5zj72t8zqZ6QVZvnU5gV1azY96dySBL%2FjWbj2uac%3D&reserved=0). We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.