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 |
|       |       |
|       |       |
|       |       |
|       |       |
| 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.