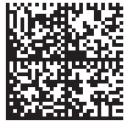
Functional Requirements Questionnaire

Return To ICBC
PO BOX 2121, STN TERMINAL
VANCOUVER BC V6B 0L6

Fax 1-877-686-4222



CLAIM NUMBER	EMPLOYEE NAME
EMPLOYEE JOB TITLE/POSITION	
COMPANY NAME	

To be completed by employer for above named employee

1. Describe the employee's duties and hours of work.

2. Please indicate which of the following type of work the employee MUST be able to do during their day:
   - ☐ **Sedentary Work**: Lifting 5 kg/11 lbs maximum, mainly seated but occasionally standing or walking about within an office setting. Occasionally lifting and carrying.
   - ☐ **Light Work**: Lifting 10 kg/22 lbs maximum, with frequent lifting and carrying of objects up to 5 kg/11 lbs. Significant walking or standing may be required.
   - ☐ **Medium Work**: Lifting 22 kg/50 lbs maximum, with frequent lifting and carrying of objects weighing up to 10 kg/22 lbs.
   - ☐ **Heavy Work**: Lifting 45 kg/100 lbs maximum, with frequent lifting and/or carrying of objects weighing up to 22 kg/50lbs.
   - ☐ **Very Heavy Work**: Lifting greater than 45 kg/100 lbs maximum, with frequent lifting and carrying of objects weighing 22 kg/50 lbs or more.

   Additional notes or comments:

3. Please indicate what the employee MIGHT BE REQUIRED to do in a regular work day (8 hours/day):
   *Please note — include possibility for overtime hours.

Stand or Walk	☐ 1–3 hrs	☐ 4–6 hrs	☐ 6–8 hrs	☐ 8+ hours
Sit	☐ 1–3 hrs	☐ 4–6 hrs	☐ 6–8 hrs	☐ 8+ hours
Drive	☐ 1–3 hrs	☐ 4–6 hrs	☐ 6–8 hrs	☐ 8+ hours

Additional notes or comments:

4. Check which of the following activities are required of this employee on an AVERAGE DAY. Please indicate if applicable, the average weight involved in kgs or lbs.

☐ Sitting/Driving	☐ Working above shoulder height	Avg. Weight	________ kg	________ lbs
☐ Standing	☐ Carrying	Avg. Weight	________ kg	________ lbs
☐ Walking	☐ Pushing	Avg. Weight	________ kg	________ lbs
☐ Climbing	☐ Bending/Twisting	Avg. Weight	________ kg	________ lbs
☐ Running	☐ Reaching	Avg. Weight	________ kg	________ lbs
☐ Kneeling/Crouching	☐ Lifting	Avg. Weight	________ kg	________ lbs
☐ Keyboarding	☐ Use of Tools, etc.			
	☐ Large Tools			
	☐ Fine Tools			

5. How often do employees take breaks each day/shift? (i.e., meal and coffee breaks)

# OF BREAKS		MINUTES			
________	X	________	=	________	minutes
________	X	________	=	________	minutes

6. Are break times flexible? (i.e., During the employee's recovery, would he/she be permitted to take breaks more often, or when needed, rather than at a scheduled time?) ☐ Yes ☐ No

7. Does this employee normally work overtime? ☐ Yes ☐ No

   If yes, please provide details regarding # of hours/per week or month, and the pay rate.

   ____

   ____

   ____

   ____

8. Does your company support any of the following?

   Graduated Return to Work ☐ Yes ☐ No

   Return to Work with Limitations (i.e., Light or reduced duties) ☐ Yes ☐ No

   Do you have a Return to Work (Disability Management) Program? ☐ Yes ☐ No

   If yes to any of the above questions, please provide the name and phone number of the person who should be contacted to arrange a return to work program.

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   ____

   ____

   ____

9. Are there any obstacles or challenges for the employee to return to work? ☐ Yes ☐ No

   If yes, please provide details:

   ____

   ____

   ____

   ____

To be completed by employer for above named employee (cont'd)

10. What job modifications can be made to accommodate the employee during the rehabilitation period? (i.e., Can the work site be modified and/or are light duties available for the employee?)

11. Describe any potential hazards the employee, other employees, or the workplace may be exposed to if the employee returns to work before full recovery.

12. List the sources of your employee's wage/disability and extended Health benefits. (Please provide details of coverage available or attach a copy of the plan coverage.)

13. Is an ergonomic assessment required? ☐ Yes ☐ No

14. If you agree to a Return to Work Program with modified duties, do you require written permission from the employee's Physician regarding the job site requirements to which the employee can safely return? ☐ Yes ☐ No

15. Is the employee a union worker? ☐ Yes ☐ No

    If yes, please provide the name of the union/local and contact information.

16. Are there provisions in the collective agreement regarding Return to Work Programs? ☐ Yes ☐ No

    If yes, please provide complete details:

17. Please make any additional comments you feel are relevant by attaching a separate page to this questionnaire.

Personal information on this form is being collected under section 26 of the *Freedom of Information and Protection of Privacy Act* (BC) and section 29 of the *Insurance (Vehicle) Act* (BC) for the purpose of investigating, managing or settling the claim. Questions about the collection of this information may be directed to the **adjuster**, or call 604-661-2800 or contact the Privacy & FOI Department at 151 W Esplanade, North Vancouver, BC V7M 3H9.

SIGNATURE OF PERSON COMPLETING FORM

DATE COMPLETED

PRINT NAME

PHONE NUMBER

JOB TITLE

E-MAIL ADDRESS