WorkplaceNL

MAIL FORM TO:
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VISIT US AT:
workplacenl.ca

Please indicate applicable number
CLAIM NUMBER (Worker)

NON-SPECIFIC INCIDENT REPORT – EMPLOYER'S CHECKLIST

PLEASE COMPLETE IN CONSULTATION WITH AN EMPLOYER REPRESENTATIVE WHO IS FAMILIAR WITH DAY TO DAY WORK IN THIS POSITION.

WORKER'S NAME

JOB TITLE | NUMBER OF YEARS IN JOB | NUMBER OF YEARS WITH EMPLOYER

1 WHAT ACTION IF ANY HAS BEEN TAKEN SINCE CLAIM SUBMITTED? *(check all applicable)*

☐ Work Station Review ☐ Job Site Analysis ☐ Modified Duties ☐ Lost Time
☐ Other Describe ______

SPECIFIC JOB INFORMATION	PERCENTAGE OF WORK DAY SPENT PERFORMING TASK			
ESSENTIAL TASKS	NOT AT ALL SELDOM (not daily) MINOR (0-10%)	OCCASIONALLY (11-33%)	FREQUENT (34-66%)	CONSTANT (67-100%)
1.				
2.				
3.				

2 RECENT WORK SCHEDULE: Shift Length/total number of hours ______

Hours worked per week ______ Overtime Hrs/Hrs Outside Regular Hours ______ Any changes to schedule? ☐ Yes ☐ No
Seasonal ☐ Yes ☐ NO

3 PLEASE DESCRIBE ANY CHANGES IN WORK TASKS
______

4 CHANGE IN WORK EQUIPMENT (eg. desk, chair, computer, handtools)? ☐ Yes ☐ No
If YES, please describe ______

5 PACE OF WORK? ☐ Low (task are intermittent) ☐ Medium (tasks are performed at a steady controlled pace)
☐ High (tasks are performed up to maximum speed, controlled by external factors)

6 ABILITY TO TAKE SCHEDULED BREAKS? ☐ Yes ☐ No

8 ☐ Does the worker alternate from one task to another? OR ☐ Do they perform one task for long periods (i.e. 1.5 hrs) before a change in activity?

9 What do you feel is the cause of the workers problems? ______
______

10 Any other information you would like to provide regarding this worker's job, and/or injury? ______
______

11 Are you aware of any outside activities that may contribute to worker's problems? ______
______

IF YOU WOULD LIKE TO PROVIDE ADDITIONAL INFORMATION PLEASE FEEL FREE TO ATTACH A LETTER TO THIS REPORT.

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EMPLOYER REPRESENTATIVE SIGNATURE ______ DATE ______
YY MM DD