WorkplaceNL Health Safety Compensation

PO#:

Worksite Occupational Rehabilitation (WSOR) Initial Report

Date of service: _____

Injured worker's name:		**Claim number:**	
Employer:		**Workplace injury/ Part of body:**	

Employer Information:

Job title: **Employer:**	**Typical shift schedule:**
Hours of work: **Date of worksite visit:**	**Source of job information:**

List of essential job duties of pre-injury position:

Employer name and contact information:	**Method of Contact with employer:** Worksite visit ☐ Phone ☐ Email ☐ **Date of employer contact:**

Outcome of initial discussion with employer regarding availability and options for WSOR:

Workday tolerance:			Strength level:		
N/A	Seldom	Minor	Occasional	Frequent	Constant
Not Able	Not daily	0-10% shift (<1hr)	11-33% shift (1-2.5hrs)	34-66% shift (2.5-5hrs)	67-100% shift (>5 hrs)

Relevant Functional Tolerance Summary:

Functional tolerance	Worker's initial status	Targeted goals

Comments/Summary:

Vendor Information:

Licensed Practitioner (LP) name		Clinic name	
LP number		Vendor number	
Email address		Treatment site	
Phone number			
Date:		Signature:	