



**APPLICATION TO THE
REHABILITATION COMMITTEE
(FOR BCGEU SUPPORT STAFF EMPLOYEES)**

Application No.

--

PLEASE NOTE: ALL COSTS FOR THE COMPLETION OF THIS FORM IS THE RESPONSIBILITY OF BCIT. PLEASE INVOICE FOR BCMA FEE FORM A0032, AND RETURN WITH COMPLETED FORMS.

The joint Employer/Union Rehabilitation Committee is designed to encourage and facilitate the early return to gainful employment of employees who have become ill or injured. The Rehabilitation Committee reviews, modifies and approves your plan. BCIT assists the Rehabilitation Committee by making resources available to help you return to work. This application is to be completed by:

- A employees returning to work on a trial basis under the short term illness or injury plan (STIIP),
- B employees who have applied for or been accepted under the Long-Term Disability Plan (LTD),
- C employees who are unable to perform the duties of their own occupation due to medical reasons.

INSTRUCTIONS FOR COMPLETING APPLICATION

- 1 Section A completed by employee.
- 2 Section B completed by physician.
- 3 Section C completed by employer.

PURPOSE OF APPLICATION

- STIIP Trial - Section A, B
- Employee has applied to LTD - Section A, B, C
- Application for alternate employment due to medical reasons - Section A, B, C

SECTION A - EMPLOYEE INFORMATION			
Name		Date of Birth M D Y 	
Current Address			Postal Code
Home Phone No. () -		Department	
Work Phone No. () -		Work Fax No. () -	
Campus Address			Postal Code
Last Day Worked M D Y 	Benefit Start Date M D Y 	Which of the following benefits are you currently receiving? STIIP <input type="checkbox"/> LTD <input type="checkbox"/> CPP Disability <input type="checkbox"/> WCB <input type="checkbox"/>	
WCB Claim No. if applicable			
Physician's Name	Address _____		
	City		Postal Code
	Phone No. () -		Fax No. () -

Employee Feedback (Why are you unable to perform the duties of your position?)

(What aspects of your job, do you feel would aggravate your condition?)

EMPLOYEE AUTHORIZATION

I hereby authorize my physician/specialist, BCIT, and any rehabilitative agency to release any pertinent non diagnostic information for the purposes of return to work planning to the members of the Rehabilitation Committee. However, this is not an admission that I am able to pursue substantial gainful employment.

Applicant's Signature **X** _____ Date Signed _____

SUMMARY OF EMPLOYEE'S EDUCATION, TRAINING AND EXPERIENCE

Previous Job Experience - Include Dates and a Brief Description of Duties

Other Employment Interests

Other Interests and Hobbies

List Class(es) of Valid Driver's Licence _____ License Restrictions

ADDITIONAL EDUCATION AND TRAINING

Describe Secondary, Post Secondary, Courses and Training ()
 Start with the highest level achieved and specify the Degrees, Certificates or Diplomas completed

Name of Institution	Location	Years of Attendance	Area of Study	Certification	Yes	No

SKILL/EXPERIENCE

Check areas of skills

- Word Processing
- Accounts (AP/AR)
- Inventory
- Shipping/Receiving
- Trades - Specify _____
- Other- Specify _____
- Computer Systems Software - Specify _____
- Computer Systems Hardware - Specify _____
- Calculator
- Minute Taking
- Data Entry
- Switchboard
- Dictating Equipment
- Payroll

INFORMATION TO PHYSICIAN

Your patient has submitted an application to the joint Union/Management Rehabilitation Committee with the British Columbia Institute of Technology on the basis of a medical condition which may have rendered him/her currently incapable of performing the duties of his/her occupation. The Rehabilitation Committee has the responsibility for reviewing and approving return to work plans.

Please Forward this Report to:

Human Resources
British Columbia Institute of Technology
3700 Willingdon Avenue, Burnaby, B.C., Canada, V5G 3H2

Last Examination Date _____

Are the patient's limitations Permanent Temporary
Is this a condition which will recur? Yes No Yes No Anticipated Return Date
Is your patient currently capable of performing the duties of
his/her own occupation as described on the previous pages? _____
If no, will your patient be able to return to other gainful, productive employment? _____
On a graduated or modified basis? _____
If yes, when could a rehabilitation or a return to work plan commence? _____
What limitations or restrictions would you advise for your patient in relation to returning to gainful, productive employment?

Additional Comments:

Physician's Name _____

Address _____

City _____ Postal Code [][][][][][][][][]

Fax No. () [][][][][][][][][] Phone No. () [][][][][][][][][]

SIGNATURE **X** _____ Date Signed _____

SECTION C — JOB ASSESSMENT SUMMARY - To be completed by the Supervisor or Designate.
Feel free to contact OHS if you require further assistance.

Duties	Percentage of Time	Duties	Percentage of Time

WORK ENVIRONMENT

	Yes	No	No. of Times Per Day	No. of Hours Per Day
Does the employee's job require work in any of the following conditions?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
In extreme cold or heat	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
In a damp or humid environment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
In a noisy environment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
In a dusty or unventilated environment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
In toxic fumes and vapors	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Flooring surface (Type) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Working alone	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Does job involve handling chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
If yes, please list:				

STRENGTH

Does the job require the employee to lift, carry or move:				
More than 100 lbs (25 Kgs)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
More than 50 lbs (23 Kgs)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
More than 20 lbs (9 Kgs)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
More than 10 lbs (4 Kgs)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Less than 10 lbs (4 Kgs)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Does the employee use any lifting/moving devices?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

MOBILITY

Does the job involve:				
Balancing	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Repetitive movement	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Standing	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Bending/Couching/Kneeling/Crawling/Stooping	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Walking	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Driving	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Remaining in one position for more than an hour	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Reaching above shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Reaching below shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Reaching at shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

DEXTERITY		VISION		COMMUNICATION	
How much of the employee's work requires:		How much of the employee's work requires:			
Finger dexterity?	Right hand _____%	Sharpness of vision?	Near _____%	Talking	_____%
	Left hand _____%		Far _____%	Writing	_____%
Hand dexterity?	Right hand _____%	Color discrimination?	_____%	Listening/Hearing	_____%
	Left hand _____%	Reading?	_____%		
Foot pedal usage?	Right foot _____%	Computer screen viewing?	_____%		
	Left foot _____%	Depth discrimination?	_____%		

EQUIPMENT USE — List any office machines, tools or any other equipment that the employee is required to use in this job.

Types of Equipment	No. of Times	No. of Hours	Types of Equipment	No. of Times	No. of Hours

Please provide background as to what accommodations or actions have taken place to date? (Training, Skill Testing, Job Searches, Modified Hours/Duties, etc.,)

BCIT Supervisor's Signature **X** _____ Date Signed _____