

The WORK Ability Management Group / Industrial Case History

Company Data / Demographics	
Company Name	
Company Headquarters	
Your Name	
Your Title	
Phone	
Email Address	

Nature of Company	<input type="checkbox"/> light manufacturing		<input type="checkbox"/> heavy manufacturing		<input type="checkbox"/> construction						
	<input type="checkbox"/> technology		<input type="checkbox"/> service		<input type="checkbox"/> government						
Number of employees	<input type="checkbox"/> 0-50	<input type="checkbox"/> 51-100	<input type="checkbox"/> 101-200	<input type="checkbox"/> 201-500	<input type="checkbox"/> 501-1000	<input type="checkbox"/> 1000 +					
	Employee Demographics										
% < 25 years of age											
% 25-50											
% over 50											
% involved in material handling activities											
% smokers											
% full time											
% part time											
Average length of employment											
Union workers					<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Shift work					<input type="checkbox"/> Yes	<input type="checkbox"/> No					

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Types of Health Problems		
Injury Data (from the previous 2 years)	No. of back and neck injuries	
	No. on disability	
	Average no. lost work days	
	Average cost per injury	
	No. of wrist and hand injuries	
	No. on disability	
	Average no. lost work days	
	Average cost per injury	
	No. of head injuries	
	No. of lower extremity injuries	
	No. of slips and falls	
	No. of burns	
Other		
No. currently in litigation		
No. currently in rehab		

Where and when did most of the injuries occur?		
What is the type of employee most often injured?	<input type="checkbox"/> 18-25 years of age	<input type="checkbox"/> male
	<input type="checkbox"/> 25-50	<input type="checkbox"/> female
	<input type="checkbox"/> > 50	
	Length of employment	
Union member	<input type="checkbox"/> Yes <input type="checkbox"/> No	

What Are the Health Practices of the Company?					
Do you have?	Pre-placement physicals		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Annual health physicals		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Return to work program		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Stay at work program		<input type="checkbox"/> Yes <input type="checkbox"/> No		
	Transitional work program		<input type="checkbox"/> Yes <input type="checkbox"/> No		
What is your return to work policy?					
How would you rate your employees' perception of the health and safety policies of your company?	Very positive <input type="checkbox"/>	Mostly positive <input type="checkbox"/>	Neutral <input type="checkbox"/>	Mostly negative <input type="checkbox"/>	Very negative <input type="checkbox"/>
What do you think is the most pressing health and safety concern facing your company?					