

HEALTH CARE PROFESSIONAL'S GUIDE to WCB



WORKERS' COMPENSATION BOARD

Northwest Territories

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Dear Health Care Professional:

It is our hope that the information presented will supplement your knowledge of the Workers' Compensation Board and enhance health care provided to injured workers of the Northwest Territories.

Enhanced service to injured workers can only exist when there is effective communication among all involved. To that end, the WCB recognizes health care professionals as important team members and encourages open communication among all stakeholders involved in the process of treating and returning the injured to work.

Opportunities and invitations for your participation as a team member are presented in the guide. You are encouraged to read the guide and become familiar with the rehabilitation and return to work processes available to injured workers in your area.

This edition of the Health Care Professionals' Guide to WCB introduces a new section that contains reference material and articles from medical literature sources. The contents of the previous manual have been rewritten with a new format to improve the usefulness of the guide. Your comments regarding this guide and requests for future content consideration are most welcome.

Thanking you in advance for your service in the provision of medical care to our clients, your patients.

Most sincerely,

*David P. King, M.D., M.A.C.O.E.M.
Chief Medical Advisor*

WHAT IS THE WORKERS' COMPENSATION BOARD?

Workers' compensation is essentially a form of social insurance. Employers pay assessments into a common fund, out of which benefits are paid to workers or their dependents.

The four key elements and founding principles of workers' compensation are:

No-Fault Compensation – Compensation is available to injured workers regardless of negligence on the part of the workers, co-workers or employers. In return, workers surrender their right to sue their employers for liability.

Collective Liability – Employers share the cost of compensating injured workers.

Independent Administration and Adjudication – Workers' compensation administers an insurance program in a manner designed to provide equitable service and protection to both workers and employers.

Exclusive Jurisdiction – Decisions of the WCB are not subject to court review.

Workers' compensation was first introduced to the NWT in 1953. At that time, employers were individually liable for accident costs through private sector insurance. A general accident fund and collective liability for NWT employers became reality in 1977.

In the NWT and Nunavut, the *Workers' Compensation Act* is governed by a board of seven directors who represent the interests of labour, industry and the public sector. Of these members, one is appointed chairperson of the Board. Term appointments to the Board of Directors are made by the Minister for the Workers' Compensation Board. The WCB does not report to a minister, but rather, through a minister, to the NWT and Nunavut Legislative Assemblies.

WHAT DOES THE WCB DO?

The WCB has four responsibilities. They are:

- ◆ to ensure that compensation and pensions are awarded to injured workers or their dependents and are paid in accordance with entitlement;
- ◆ to assess employers sufficiently and fairly to meet these obligations;
- ◆ to maintain a balance in providing benefits to injured workers while keeping assessment costs to employers as low as possible; and
- ◆ to promote safe workplaces through education and enforcement.

To meet these responsibilities, the WCB has established and maintains adequate reserves, which are called the Accident Fund. The Accident Fund is maintained from the revenue collected from employer assessments and investments.

RIGHTS AND RESPONSIBILITIES

Three parties are always involved in a claim for compensation. They are:

- the worker;
- the employer; and
- the health care professional.

Each has an important and unique role to play.

WORKER

Rights:

- automatic no fault coverage for work-related injuries/illness
- prompt claim adjudication and payment of benefits
- timely access to professional health care and, when required, vocational rehabilitation services to assist with return to work
- a lifetime pension if there is a remaining permanent disability after maximum recovery is achieved

Responsibilities:

- to work safely by following established safety rules and bringing unsafe working practices or conditions to the supervisor's attention
- to advise the employer and submit a claim as soon as is practicable after an injury
- to take active responsibility for own recovery by following the prescribed treatment
- to attend scheduled appointments and ask for clarification if instructions are not understood
- to accept modified or alternative duties when offered and if within capabilities, as identified by the health care professionals
- to advise the WCB immediately upon return to work

EMPLOYER

Rights:

- protection from lawsuits by own workers in the event of an injury at work
- access to sufficient worker medical information to develop an effective “return to work” program
- ability to question the work relatedness of a reported injury

Responsibilities:

- to maintain a safe workplace, making sure workers are aware of and follow safe operating procedures
- to ensure payroll submissions are current and premiums are paid
- to provide a complete accident report to the WCB within 3 days of becoming aware of a work-related injury, and a copy of the report to the injured worker

HEALTH CARE PROFESSIONAL

Rights:

- timely payment for medical services rendered and reports submitted
- access to additional medical information, research and services through the WCB Medical Unit

Responsibilities:

- to provide timely, accurate and complete medical reports to the WCB as required or requested
- to promote optimal functional restoration through active recovery management

THE CLAIMS PROCESS

The *Workers' Compensation Act* applies to all workers and employers who carry on an industry in the NWT and Nunavut. Renewable resource harvesters (those engaged in hunting, fishing or trapping) also have access to compensation.

In addition to obvious physical injury, the Act also covers industrial diseases which arise out of and during the course of employment. Examples of some common industrial diseases are: repetitive motion disorders (e.g., epicondylitis, silicosis, dermatitis, vibration-induced white finger disease (white hand syndrome) and noise-induced hearing loss.

A worker's claim can only be processed when all three of the following reports have been received:

- medical report
- worker's report
- employer's report

A delay in this initial process will delay the worker's assessment for entitlement.

When the above reports are received by the Client Services Division, entitlement is assessed and the claim is either accepted or denied. If the claim is denied, the WCB will pay the costs of the examination, the reporting fee, and any treatment or procedures for this initial visit.

The goal for injured workers is to return to work in the most appropriate, coordinated, timely and safe manner. Vocational rehabilitation is available to help workers return to work. When a permanent disability results from a work-related injury, the WCB provides a pension related to the degree of disability.

MISCONCEPTIONS

MISCONCEPTION #1

“So many people complain about WCB. There must be something seriously wrong over there.”

In 2004, 3067 claims were reported to the WCB. There were 93 applications for review from injured workers or their dependents involving 83 claims issues, 20 pension issues, 9 rehabilitation issues and 1 revenue issues. Three percent (3%) of all claimants in 2004 were not happy with a WCB decision and requested a review. In other words, 97 percent (97%) of all claimants in 2004 were satisfied with decisions made on their claims.

MISCONCEPTION #2

“I’ve been paying for WCB for years. Now that I’ve had this accident, I’m just getting my money back!”

Workers do not contribute to the WCB. In fact, subsection 84(1) of *the Workers’ Compensation Act* makes it illegal for “any employer, either directly or indirectly, to deduct from the wages of his or her workers any... sum that the employer is ...liable to pay to the Board.”

MISCONCEPTION #3

“Why can’t the government pay more to injured workers?”

The Workers’ Compensation Board is not a division of the GNWT. It is, in essence, an independent insurer that provides collective liability coverage to employers for their workers. WCB benefits are funded entirely by employer assessments and returns on WCB investments. The GNWT does not contribute any tax dollars to the benefits of injured workers.

MISCONCEPTION #4

“Nobody can get by on what the WCB pays...”

The Workers' Compensation Board compensates injured workers for wages up to 90 percent of net of the Year's Maximum Insurable Remuneration (YMIR). (Effective January 1, 2004, the YMIR was \$66,500.) In its annual determination of the YMIR, the Workers' Compensation Board is committed to ensuring that 70 to 80 percent of the NWT and Nunavut work force is fully compensated in the event of a work-related injury.

In addition, injured workers receiving pensions have their rates reviewed annually and supplementary increases are provided based primarily on the Consumer Price Index.

THE WCB MEDICAL UNIT

The Medical Unit of the Workers' Compensation Board is comprised of two physicians, two nurses and support staff. We see our role as members of the overall Health Service Provider team and, to that end, we communicate and liaise with other Health Care Service Providers to ensure the best medical management for injured workers. Our pro-active approach reinforces the Board's philosophy of a safe and timely return to work and reflects the Canadian Medical Association's policy on "The Physician's Role in Helping Patients Return to Work After an Illness or Injury."

The specific duties of the Medical Unit include:

- serving as medical information resources for the claims adjudicators, rehabilitation counsellors, Review Committee and Appeals Tribunal members, and health care service providers in the community;
- advising on entitlement of worker, work-relatedness of injury and causation;
- advising and overseeing medical treatment and investigation;
- doing assessment examinations for the purpose of determining diagnosis, progress of treatment and recovery, fitness for return to work and vocational rehabilitation and permanent medical impairment (pensions) entitlement;
- expediting treatments, consultations, investigative procedures; and
- visiting work sites.

We welcome phone calls from health service providers. Please call to discuss medical case management or for information. The Board's library maintains a section of occupational medicine and we have access to medical searches if referenced literature is required.

The Medical Unit may be reached from
8:30 a.m. to 5:00 p.m. (mountain time) at
(867) 920-3851
toll free 1-800-661-0792
fax (867) 669-4474

IMPORTANT POLICY STATEMENTS FOR HEALTH CARE PROFESSIONALS

Choice and Change of Health Care Professional

The WCB recognizes the importance of a worker's choice of physician or qualified practitioner and the contribution that a relationship of trust makes to a successful treatment program. The WCB does, however, reserve the right to refuse the choice or change of practitioner by a worker if it views the selection as potentially detrimental to the worker's recovery.

Prescription Drug Use

The WCB is committed to encouraging responsible prescription drug use. The WCB will monitor drug prescriptions for work-related injuries to ensure that they are not prescribed in excessive amounts and do not have adverse effects on the worker's health and general well being.

Medical Apparatus

The WCB will provide medical apparatus (i.e., glasses, a hearing device, wheelchair, orthotic device, prosthetic device, etc.) to injured workers when:

- it is required because of a compensable injury; or
- medical apparatus that was damaged in an accident which arose out of and during the course of employment needs to be replaced.

The medical apparatus must be prescribed by the worker's treating physician or other qualified health care practitioner.

Alternative Treatment

Alternative forms of treatment may be considered in certain circumstances to enable an injured worker to regain the condition which existed prior to the work-related injury or to give relief from any continuing effects of injury. Alternative treatments include acupuncture, chiropractic treatment, massage therapy, physiotherapy and podiatric treatment delivered by qualified personnel.

WHEN SHOULD THE INJURED WORKER RETURN TO WORK?

The Workers' Compensation Board has prepared Disability Duration Guidelines which may be used as a "yardstick" in determining what a reasonable period of absence from the workplace would be for a variety of compensable illnesses and injuries. In short an injured worker should return to work when it is "safe" and when further absence from the work site will not contribute to the recovery process. We must be cognizant of the fact that returning to work has therapeutic value.

When an individual hasn't returned to work within a reasonable recovery period we must look at the case again to determine the barriers for return to work:

- Is the diagnosis correct?
- Is there evidence of complication or concurrent illness to account for prolonged recovery?
- Is a chronic pain syndrome developing?
- Are there psychosocial factors responsible for continued disability?

The Board has staff physicians and access to specialist services to assist in cases of diagnostic dilemma and treatment failures. We are also available for assistance and recommendations regarding fitness for return to work and return to work processes (including modified and ease back programs and the involvement of Vocational Rehabilitation Counsellors).

The benefits of returning to work following any illness or injury cannot be overstated. The Medical Department of the Workers' Compensation Board strongly endorses the Canadian Medical Association's policy on "The Physician's Role in Helping Patients Return to Work After an Illness or Injury" (copy enclosed). We are of the opinion that all health care providers will be doing our clients a great service if the spirit and principles of this policy are incorporated into the overall treatment plans being provided.

REPORTS, FORMS AND FEES

DUTY TO REPORT

Section 17.3 of the *Workers' Compensation Act* states:

“A health care provider who attends to a worker who has suffered or has reported that he or she has suffered a personal injury as the result of an accident arising out of and during the course of the worker’s employment shall send the Board a report within three days after the date of his or her first attendance on the worker.”

REPORT FEES

Additional information may be requested by WCB staff and is to be submitted by completion of a form (if provided) or by a letter with photocopies of pertinent documents included.

The Northwest Territories Medical Association has negotiated a three (3) year report fee agreement with the WCB. Commencing January 1, 2004, the report fee schedule is:

- Form Completion Fee \$32.50
- Detailed Medical Report (at the request of WCB) Fee.... \$150.00

Please note that the form must be completed in its entirety and in a legible manner to receive the reporting fee payment. Incomplete and illegible forms will be returned by claims adjudication staff for attention and re-submission.

MEDICAL REPORTS

The Health Care Professional, attending an injured worker, is required to submit relevant medical information to enable the Workers' Compensation Board staff to enact the legislation.

The treating Health Care Professional plays a critical role in the process by identifying the medical problems(s) and presenting an accurate diagnosis and effective treatment plan. Communication among all stakeholders involved (Health Care Provider, WCB staff, employer and the worker) is critical for expedited claim processing, provision of benefits and treatments and successful return to work outcomes. Copies of medical documents obtained through Board arrangements, such as medical investigative reports, treatment and medical consultation reports, will be forwarded to the attending physician(s) to ensure effective communication.

The Health Care Professional's information is primarily communicated through the completion of WCB report forms, which include:

- first medical report
- medical progress report
- dental report
- eye injury report
- hand injury report
- physio/occupational therapy reports (4)


Printed forms are supplied to hospitals, doctor's offices, physiotherapy clinics, community health centres, dental offices and chiropractic clinics.

**TO ORDER ADDITIONAL FORMS for your clinic, please phone the
Public Affairs Office of the Workers' Compensation Board
at 920-3888 or 1-800-661-0792.**

This Guide includes:

1. Examples of all Medical Reporting forms.
2. "Form Completion" Samples of the First Medical Report and Medical Progress Report.
3. Yellow photocopy masters of selected forms, to be used in the event that you run out of printed forms.

First Medical Report

 WORKERS' COMPENSATION BOARD Northwest Territories and Nunavut		First Medical Report	
PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN TO ADDRESS ON REVERSE			
		WCB Claim Number	
Name of Health Care Professional		Worker's last name first name	
Address - include postal code		Postal address - include postal code	
Telephone - include area code		Residential Address	
Accident date YY MM (N)		Telephone - include area code	
Examination date YY MM (N)		Date of birth YY MM (X) Social Insurance Number	
Employer's name		Worker's occupation	
1. Would you like a WCB Doctor to contact you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Current Work Disability Please estimate the period of disability from date of this exam. Estimated return to work date YY MM (U)			
3. Current Work Capability (See back for definitions)			
<input type="checkbox"/> Not able to work <input type="checkbox"/> Limited <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy			
4. Worker's account of injury. How did it happen?			
5. Subjective complaint			
6. Objective medical findings (include height and weight and advise if injury is to dominant limb)			
7. Describe any significant previous disease or injury			
8. Investigations (Lab / X-rays / CT etc)			
9. Diagnosis			
10. Prescribed treatment/advice/referrals			
11. Has worker been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital Name			
12. Is permanent disability probable? <input type="checkbox"/> Yes <input type="checkbox"/> No			
13. Will worker be seen again? <input type="checkbox"/> Yes <input type="checkbox"/> No When? By whom?			
Signature of person completing form _____ Date _____			

Supplier Number _____

Fee Submitted

Board - the worker necessary or as may be of the physician, able to

0 kg and 20 kg.

threw furniture by hand walls of electrical components

Examples:

- operating and maintaining work equipment and performing other
- deck duties aboard ships
- shoveling cement and other materials into cement mixers and performing other activities to assist in the maintenance and repair of roads
- measuring, cutting and fitting drywall sheets for installation on walls and ceilings

High Office: Box 8888 • Yellowknife, NT X1A 2R5 • Telephone: (867) 922-3388 • Toll Free: 1-800-661-0792 • Fax: (867) 873-1090

Box 606 • Igarka, NT X0A 3H0 • Telephone: (867) 979-8502 • Toll Free: 1-877-451-1407 • Fax: (867) 979-8501

Box 265 • Rankin Inlet, N. X0C 0K5 • Telephone: (867) 845-5800 • Toll Free: 1-877-412-0675 • Fax: (867) 845-5900

* Completion by Physicians, Nurses and Chiropractors to document first presentation of an injury/illness by the worker.

Form Completion Sample

"First Medical Report"


Current Work Disability pertains to the worker's usual job duties. In this example, the worker has an uncomplicated fracture of a metacarpal. The Duration Guide indicates 6-12 weeks for medium to heavy work. The worker may be unable to do his regular job for this period of time. However, with the fracture immobilized, he is returning to limited or light duties much earlier.

The health care provider indicates the level of work capability. WCB staff will follow up with the employer regarding availability of modified duties.

Quote the patient - how does he/she describe it?

Objective

What can you see and measure?

 WORKERS' COMPENSATION BOARD <small>Northwest Territories and Nunavut</small>		First Medical Report	
PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN TO ADDRESS ON REVERSE		WCB Claim Number:	
Name of Health Care Professional A NURSE		Worker's last name first name CLAIMANT BAL	
Address - include postal code COMMUNITY		Postal address - include postal code Box 99, COMMUNITY NT XOP 2R9	
Telephone - include area code 1-367-333-8888		Residential Address	
Accident date YY MM DD 98 01 22		Telephone - include area code 1-367-333-6666	
Examination date YY MM DD 98 01 22		Date of birth YY MM DD Social Insurance Number 64 09 15 444-444 222	
Employer's name MATOR EMPLOYER INC.		Worker's occupation Carpenter's Helper	
1. Would you like a WCB Doctor to contact you? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
2. Current Work Disability: Please estimate the period of disability from date of this exam. 3. Estimated return to work date YY MM DD <input type="checkbox"/> No disability <input type="checkbox"/> 1-7 days <input type="checkbox"/> 8-14 days <input type="checkbox"/> 15-21 days <input type="checkbox"/> More			
4. Current Work Capability: (See back for definitions): <input type="checkbox"/> Not able to work <input type="checkbox"/> Limited <input checked="" type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy			
5. Worker's account of injury. How did it happen? shingling roof - fell off roof, landing on pile of lumber			
6. Subjective complaint - bad pain @ shoulder, @ flank, @ hand - "can't move my fingers" @ hand.			
7. Objective medical findings (include height and weight and advise if injury is to dominant arm): - abrasions @ side of face, @ upper arm, @ flank, 5'10" 185 lb. - swelling @ 3rd finger.			
8. Describe any significant previous disease or injury: - previous dislocation @ shoulder 1991			
9. Investigations (Lab / X-rays / etc): X rays: undisplaced fracture @ 3rd metacarpal; shoulder normal			
10. Diagnosis: @ fracture @ 3rd metacarpal @ abrasions contusions @ arm and flank.			
11. Prescribed treatment/advice/referrals: - splint to @ 3rd finger - sutured cut left cheek (5 stitches) Tylenol #3.			
12. Has worker been hospitalized? Yes <input checked="" type="checkbox"/> No Hospital Name:			
13. Is permanent disability probable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
14. Will worker be seen again? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No When? By whom? visiting physician - 1 week.			
Signature of person completing form: A. Nurse		Date: 98/01/22	

Medical Progress Report



WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

Medical Progress Report

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN TO ADDRESS ON REVERSE

WCB Claim Number _____

Name of Health Care Professional		Worker's last name		first name	
Address - include postal code		Postal address - include postal code			
Telephone - include area code		Residential Address			
Accident date	YY MM (D)	Telephone - include area code			
Examination date	YY MM (D)	Date of birth	YY MM DD	Social Insurance Number	
Employer's name		Worker's occupation			
1. Would you like a WCB doctor to contact you?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Current Work Disability Has the worker returned to work?		<input type="checkbox"/> Yes <input type="checkbox"/> No		3. If yes, please provide date YY MM DD	
4. If no, please estimate the period of disability from date of this exam		<input type="checkbox"/> No disability <input type="checkbox"/> 1-7 days <input type="checkbox"/> 8-14 days <input type="checkbox"/> 15-21 days <input type="checkbox"/> More		5. Estimated return to work date YY MM DD	
6. Current Work Capability (See back for definitions)		<input type="checkbox"/> Not able to work <input type="checkbox"/> Limited <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy			
7. Subjective complaint					
8. Objective medical findings					
9. Significant previous diseases/injuries					
10. Investigations if any: X-rays, CT, etc.					
11. Diagnosis					
12. Prescribed treatment/advice/referrals					
Please give details for the following questions when answered "Yes"					
13. Has worker been hospitalized?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Hospital Name	
14. Has an operation been performed?		<input type="checkbox"/> Yes <input type="checkbox"/> No		When?	
15. Any factors delaying recovery?		<input type="checkbox"/> Yes <input type="checkbox"/> No		What?	
16. Is permanent disability probable?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
17. Would you suggest an examination by a WCB doctor?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
18. Will worker be seen again?		<input type="checkbox"/> Yes <input type="checkbox"/> No		When?	

Signature of person completing form _____ Date _____

Supplier Number _____

Fee Submitted

To the Board
use on the worker
bers necessary or as may be
mon of the physician able to

been 10 kg and 20 kg.

es or finishing furniture by hand
per to walls
ical or electrical components

lifting boxes, heels and other parts of footwear
filing materials in drawers, cabinets and storage boxes
preparing and cooking meals

Heavy
Work activities involve handling loads of more than 20 kg
Examples:
operating and maintaining deck equipment and performing other
deck duties aboard ships
shoveling cement and other materials with cement mixer and performing
other activities to assist in the maintenance and repair of roads
measuring, cutting and fitting drywall sheets for installation on walls
and ceilings

Hiac Office: Box 8888 • Yellowknife, NT X1A 2R2 • Telephone: (867) 922-3888 • Toll Free: 1-800-551-0732 • Fax: (867) 873-1096
 Box 565 • Inuvik, NT XCA 0H6 • Telephone: (867) 879-8000 • Toll Free: 1-877-101-1107 • Fax: (867) 879-8501
 Box 366 • Tuktoyaktuk, NT XRT 1R0 • Telephone: (867) 845-5450 • Toll Free: 1-877-414-8878 • Fax: (867) 845-5451


* Completion by Physicians, Nurses and Chiropractors to detail each subsequent visit/examination after the initial report.

Form Completion Sample "Medical Progress Report"

Do you have concerns about:

- diagnosis?
- delayed recovery?
- expedited treatment/investigation?
- fitness for return to work?

Check the "Yes" box and we will call you OR you may call us.

 WORKERS' COMPENSATION BOARD <small>Northwest Territories and Nunavut</small>		Medical Progress Report	
PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN TO ADDRESS ON REVERSE			
Name of Health Care Professional A. NURSE		Worker's last name ADAM	
Address - include postal code COMMUNITY		Postal address - include postal code Box 44, COMMUNITY, NT X0P1L0	
Telephone - include area code 1-867-444-3223		Residential Address	
Accident date YY MM DD 96 01 01		Telephone - include area code 1-867-333-4444	
Examination date YY MM DD 98 02 17		Date of birth YY MM DD 71 12 11	
Employer's name SMALL COMPANY		Social Insurance Number 444 333 555	
Worker's occupation MAINTENANCE MAN		WCB Claim Number	
1. Would you like a WCB Doctor to contact you? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Delayed recovery			
2. Current Work Disability Has the worker returned to work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3. If yes, please provide date YY MM DD			
4. If no, please estimate the period of disability from date of this exam <input type="checkbox"/> No disability <input checked="" type="checkbox"/> 7 days <input type="checkbox"/> 8-14 days <input type="checkbox"/> 15-21 days <input type="checkbox"/> More 5. Estimated return to work date YY MM DD ??			
6. Current Work Capability (See back for definitions): <input checked="" type="checkbox"/> Not able to work <input type="checkbox"/> Limited <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy			
7. Subjective complaint - severe low back pain - cannot lift or bend, sleep disturbed due to pain - unable to do household chores.			
8. Objective medical findings - (N) SLR & neuro exam - slight restriction of flexion & lateral rotation			
9. Significant previous illnesses/injuries nil			
10. Investigations (lab / X-rays / CT etc): plain film Xray (N)			
11. Diagnosis back strain			
12. Prescribed treatment/advice/referrals NSAIDS progressive exercise, ?? Ortho referral.			
Please give details for the following questions when answered "Yes"			
13. Has worker been hospitalized? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hospital Name			
14. Has an operation been performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No When?			
15. Any factors delaying recovery? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Why? Pain			
16. Is permanent disability probable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
17. Would you suggest an examination by a WCB doctor? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
18. Will worker be seen again? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No When? prn			
Signature of person completing form: A. Nurse		Date: 98/02/17	

Refer to the DISABILITY DURATION GUIDELINES section.

If you are unsure, call us to discuss options.

Dental Report and Estimate



WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

Dental Report and Estimate

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN TO ADDRESS ON REVERSE

Name of Health Care Professional		Worker's legal name <i>first name</i>	
Address <i>include postal code</i>		Postal address - <i>include postal code</i>	
Telephone <i>include area code</i>		Residential Address	
Accident date	YY MM DD	Telephone - <i>include area code</i>	
Examination date	YY MM DD	Date of birth	YY MM DD Social Insurance Number
Employer's name		Worker's occupation	

1. Who provided first treatment?

2. Date you first treated YY MM DD

3. What does worker say caused the injury?

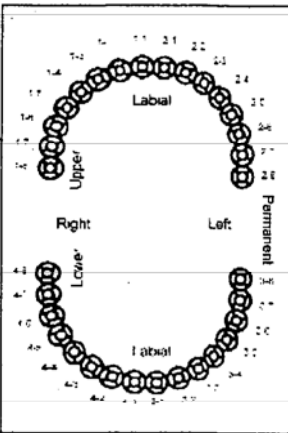
4. Describe damage resulting from accident. If damage is to dentures, please describe.

5. Please mark chart using the following symbols:

- Teeth damaged by accident
- Teeth to be extracted as a result of the accident (colour in the tooth)
- X Teeth missing (prior to accident)

6. Describe any other oral condition that may be present with your opinion as to whether or not it is due to the accident in question. If necessary, x-ray injured areas and give radiological report

7. Describe in detail your treatment plan to restore, as nearly as possible, the masticatory function to the degree existing prior to the accident.



Indication For Schedule \$

Total \$

AN ACCOUNT

Date

Forward to the Board if attendance on the worker is considered necessary or as may be in the opinion of the physician able to

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Box 1995 • Tuktoyaktuk, NT X0K 1K4 • Telephone: (867) 645-5818 • Toll Free: 1-800-414-1955 • Fax: (867) 645-5907

DATE 2012

* Completion by Dentists to detail dental damage and present a treatment plan and costs for WCB approval.

Example: A client is seen at the Nursing Station with a laceration of the upper lip and a chip from the left front tooth. The nurse would use a FIRST MEDICAL REPORT to document her observations and treatment (stitches to the lip). Later, the Dentist will address the repair of the tooth using this form.

Medical Report Eye Injuries



WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

Medical Report Eye Injuries

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN TO ADDRESS ON REVERSE

Name of Health Care Professional		Worker's last name	first name
Address - include postal code		Postal address - include postal code	
Telephone - include area code		Residential Address	
Accident date	YY MM DD	Telephone - include area code	
Examination date	YY MM (D)	Date of birth	YY MM (D) Social Insurance Number
Employer's name		Worker's occupation	
1. Would you like a WCB Doctor to contact you? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Who rendered first treatment?		3. Date you first treated this patient YY MM DD	
4. Which eye was injured? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both			
5. Vision (at your first examination and before the treatment)		Right Eye	Left Eye
6. What did the worker say caused the injury?			
7. Findings at the time of your examination (indicate on the diagram below, the location and extent of injury after fluorescein)			
Right		RIGHT	FUNDUS
Left		LEFT	
8. Treatment			
9. Is there any evidence of previous disease or injury in either eye? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes give particulars			
10. Do you expect any complications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please explain			
11. Is permanent disability probable? <input type="checkbox"/> Yes <input type="checkbox"/> No			
12. Current Work Disability Please estimate the period of disability - from date of exam		13. Estimated return to work date YY MM DD	
<input type="checkbox"/> No Disability <input type="checkbox"/> 1-7 days <input type="checkbox"/> 8-14 days <input type="checkbox"/> 15-21 days <input type="checkbox"/> More			
14. Is hospital care required? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of hospital			

Signature of person completing form _____ Date _____

Supplier Number

Enc. Submittal

If to the Board
advise on the worker
findings necessary or as may be
opinion of the physician also to

Health Services - Box 3088 • Yellowknife NT X1A 2J2 • Telephone: (867) 867-8888 • Toll Free: 1-877-867-1076 • Fax: (867) 867-4545
or
Box 308 • Ramton Inlet, NT X0C 0G2 • Telephone: (867) 867-8676 • Toll Free: 1-877-404-4443 • Fax: (867) 867-8671
• Fax: (867) 612-0502

* Completed by Nurses, Physicians or Eye Technicians on first or subsequent visits for eye injuries.

Hand Injury Report Form



WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

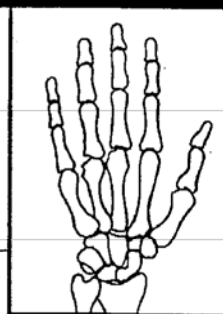
Hand Injury Report

PLEASE COMPLETE BOTH SIDES OF THIS FORM AND RETURN TO ADDRESS ON REVERSE

WCB Client Number

Name of Health Care Professional	Worker's last name	first name
Address - include postal code	Postal address - include postal code	
Telephone - include area code	Residential Address	
Accident date YY MM DD	Telephone - include area code	
Examination date YY MM DD	Date of birth YY MM DD	Social Insurance Number
Employer's name	Worker's occupation	

1. Which hand is injured? Right Left
 Which is the dominant hand? Right Left
 Note previous defects if any in Right Hand:
 Note previous defects if any in Left Hand:
2. **AMPUTATION** - Please mark by straight lines on the diagram opposite the site and direction of any amputation arising from the work-related accident.
3. **JOINTS WITH IMPAIRED MOVEMENT** - On the diagram opposite, please place an "O" on any joints in which ankylosis exists as a result of the accident, and an "X" on any joints which have permanently restricted movement as a result of the accident.
4. **FLEXION AND EXTENSION OF IMPAIRED JOINTS** - In the table on reverse for each injured joint show in degree (a) the position of utmost flexion from straight finger and (b) the lack of extension if ankylosed; show the position in which ankylosis exists. See explanation on back.



	Finger			Thumb	
	MCP/Prox.	PIP/2nd.	DIP/Distal.	MCP/Prox.	IP/2nd.
Little Finger	Position of Utmost Flexion: .....	.....	.....	Position of Utmost Flexion: .....	.....
	Lack of Extension: .....	.....	.....	Lack of Extension: .....	.....
Ring Finger	Position of Utmost Flexion: .....	.....	.....	Abduction: <input type="checkbox"/> Full <input type="checkbox"/> Restricted (Check one)	Adduction: <input type="checkbox"/> <input type="checkbox"/>
	Lack of Extension: .....	.....	.....
Middle Finger	Position of Utmost Flexion: .....	.....	.....	Opposition: <input type="checkbox"/> <input type="checkbox"/>	
	Lack of Extension: .....	.....	.....
Index Finger	Position of Utmost Flexion: .....	.....	.....
	Lack of Extension: .....	.....	.....

5. Please note any other impairment and comment on usefulness of hand (grip, wrist movement, sensation, alignment, integrity, etc.):
6. What further improvement do you expect?

I certify the above information is accurate and correct.

Attending Physician: _____ Dated at _____ this _____ day of _____ 19 _____

See other side for flexion/extension measurement explanation.

Impaired Joints

extension of finger joints has proven careful consideration, we have decided to record angle.

the distal end of a normal straight finger.

position of greatest possible flexion and extension that is required. From this will be the range of movement or, if there is ankylosis.

represent a straight extended finger. Position of injured joint.

the position of utmost voluntary flexion is the position of utmost flexion is

record the position of utmost flexion is 30°. the lack of extension is

no impairment of extension, the lack of extension will be represented in the first diagram as 60° and described as 60°.

Operator Number: _____

Submitted


Doctor's Signature: _____ services personally rendered by me

How Clinics: Box 9086 • Yellowknife, NT X1A 2R5 • Telephone: (867) 920-3892 • Toll Free: 1-800-861-0792 • Fax: (867) 673-4566
 or
 Box 665 • Inuvik, NT X0A 0J0 • Telephone: (867) 970-8500 • Toll Free: 1-877-404-4427 • Fax: (867) 970-8501
 Box 563 • Rankin Inlet, NT X1C 1X3 • Telephone: (867) 642-5610 • Toll Free: 1-877-314-8675 • Fax: (867) 642-5633

* Not Stocked in Clinics

In selected cases of injury to a hand, the Hand Injury Report form may be sent for completion. (It is normally provided to the client, with instructions to make an appointment for examination and completion of the form. Health Care Professionals are asked to provide detailed information, and send the form in. Bill for office visit and form completion fee.) Permanent Medical Impairment can be assessed by the Medical Advisor based on this information.

Physiotherapy/ Occupational Therapy Forms



WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

**Notification of
Physiotherapy/
Occupational
Therapy**

WCB Claim Number: _____ Workers' Social Insurance Number: _____

Clinic name: _____ Patient given name: _____ Initials: _____

Patient surname: _____ Postal Code: _____

Address: _____ City/Town: _____

Date of birth: YY MM DD Referring physician: _____

Estimated length of treatment program: _____ Weeks

Physiotherapy or occupational therapy diagnosis: _____

ASSESSMENT FINDINGS AND INITIAL TREATMENT:


Is there any other condition that will impede or delay the program?
 Yes No Attendance: _____

Is the patient missing time from work?
 Yes No

Goals (example: to return to work, to overcome test): _____

PRIVATE CLINIC OR HOSPITAL

Head Office: Box 8896 • Yellowknife
 Box 653 • Iqaluit
 Box 395 • Rankin Inlet



WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

**Notification of Physiotherapy/
Occupational Therapy —
Progress/Discharge Report**

WCB Claim Number: _____ Worker's Social Insurance Number: _____

Clinic name: _____

Patient surname: _____ Patient given name: _____ Initials: _____

First treatment: YY MM DD Discharge Date: YY MM DD

TREATMENT DATES (MONTH/DAY)	WEEK						
	M	T	W	T	F	S	
1							
2							
3							
4							
5							
6							
7							
8							

Treatment administered: Education Active Passive

Home program Other

Progress report due: YY MM DD

Status: Goals achieved (percentage or degrees): _____

Goals not met: _____

Reason goals not met at discharge: _____

Is the patient missing time from work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Modified/Part-time <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---	--

Discharge Summary: _____

Initial assessment findings: _____

PHYSIOTHERAPY / OCCUPATIONAL THERAPIST

Signature: _____

Name (Please print): _____

YY MM DD Telephone (include area code): _____

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Box 395 • Rankin Inlet, NT XCA 0A0 • Telephone: (867) 845-5800 • Toll Free: 1-877-414-8876 • Fax: (867) 845-5801

2000-07-11

* Exclusively completed by
Physiotherapists and
Occupational Therapists.

- 1. Notification:**
Documents first visit/assessment and treatment plan.
- 2. Progress/Discharge:**
To be sent in every three weeks while treatment continues AND when patient is discharged.
- 3. Request for Extension:**
Therapy is approved for a period of up to six weeks. All extension of treatment requests must be submitted for pre-approval.

PERMANENT MEDICAL IMPAIRMENT (PMI) / DISABILITY

Impairment may be defined as a loss or loss of use of psychological, physiological or anatomical structure or function. Permanent impairment is the residual deficit when maximal medical recovery has occurred (a static condition in spite of further medical interventions or passage of time).

Permanent impairments are assessed by medical means by the Board's physician(s) prior to the pensions officer's assignment of pensionable disability. (Disability may be defined as restriction of ability to perform specific activities as a result of impairment.) The Workers' Compensation Board has its own "NWT and Nunavut Disability Rating Guide" and utilizes the American Medical Association's Guides to the Evaluation of Permanent Impairment as a resource.

Permanent impairment assessments of workers residing in the NWT and Nunavut are conducted at the WCB office in Yellowknife or at one of the Medical Advisor's scheduled clinics held in the communities. Permanent impairment assessment of workers residing outside the NWT and Nunavut are usually conducted by medical advisors of the "home" province WCB or through independent medical evaluators. The ratings are assigned by the Medical Advisor in accordance with the NWT and Nunavut rating guide. Impairment ratings may also be calculated utilizing objective information obtained from hand injury report forms, eye injury forms and audiograms.

Whenever possible, the Medical Advisor acknowledges significant contributors of impairments of a non-compensable or pre-existing source which impact on disability.

DISABILITY DURATION GUIDELINES

**Workers' Compensation Board
of the NWT and Nunavut**

INTRODUCTION

This document has been produced to provide guidelines in estimating the usual periods of work disability sustained by workers following various work-related injuries and treatment procedures. We must be cognizant that these are reasonable duration guidelines only. The guides do not set a return to work date or indicate insurance disability benefit coverage. The upper limit of the durations represent the time when we must investigate reasons why a worker has a delayed return to work. The lower limit of the durations do not dictate required absence from work. A worker employed in a heavy work category may be able to access an earlier return to work, in a less demanding work category, provided the employer has alternate or modified work positions.

The guides are not intended to coerce injured workers back to work nor are they provided to legitimize periods of unwarranted disability. These guides do not replace the reasoned clinical judgements of attending health care professionals regarding the injured worker's absence from work during recovery. Many factors have a direct influence on recovery times including psychosocial issues, concurrent disease, age and the specific treatments prescribed as well as any untoward complications. The guides are to be utilized in conjunction with all the combined information regarding an injured worker's case in determining an appropriate disability period.

WORK CAPABILITIES / WORK REQUIREMENTS

The work capabilities/requirements categories presented in this guide are taken from the *National Occupational Classification* (NOC, 1993), which replaced the *Canadian Classification and Dictionary of Occupations* (CCDO) as the national standard.

LIMITED WORK

Work activities involve handling loads up to 5 kg.

Examples:

- examining and analyzing financial information
- selling insurance to clients
- conducting economic and technical feasibility studies

LIGHT WORK

Work activities involve handling loads of 5 kg but less than 10 kg.

Examples:

- repairing soles, heels and other parts of footwear
- filing materials in drawers, cabinets and storage boxes
- preparing and cooking meals

MEDIUM WORK

Work activities involve handling loads between 10 kg and 20 kg.

Examples:

- setting up and operating finishing machines or finishing furniture by hand
- measuring, cutting and applying wallpaper to walls
- adjusting, replacing mechanical or electrical components using hand tools and equipment

HEAVY WORK

Work activities include handling loads more than 20 kg.

Examples:

- operating and maintaining deck equipment and performing other deck duties aboard ships
- shoveling cement and other materials into cement mixers and performing other activities to assist in the maintenance and repair of roads
- measuring, cutting and fitting drywall sheets for installation on walls and ceilings

ABOVE KNEE:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited
Light

12-26 weeks
12-26 weeks

BELOW KNEE:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited
Light

12-26 weeks
12-26 weeks

FINGER:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited
Light
Medium
Heavy

0-3 weeks
0-4 weeks
2-6 weeks
4-8 weeks

FOOT – ALL TOES AT METATARSOPHALANGEAL JOINT:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited
Light
Medium
Heavy

6-8 weeks
8-10 weeks
8-16 weeks
8-16 weeks

FOOT – ANKLE – SYME'S AMPUTATION:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited
Light
Medium
Heavy

8-12 weeks
12-16 weeks
12-16 weeks
return to this work category not usually recommended

FOOT – GREAT TOE:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	2-4 weeks
Light	4-6 weeks
Medium	6-8 weeks
Heavy	6-8 weeks

FOOT – LESSER TOE:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	2-4 weeks
Light	2-4 weeks
Medium	4-6 weeks
Heavy	4-6 weeks

FOOT – MID-METATARSAL:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	8-12 weeks
Light	8-12 weeks

HIP DISARTICULATION:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	12-20 weeks
Light	12-20 weeks
Medium	return to medium & heavy work levels not usually recommended
Heavy	

AC (acromioclavicular) JOINT & SC (sternoclavicular) JOINT:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	0-3 weeks
Light	2-4 weeks
Medium	3-6 weeks
Heavy	6-12 weeks

ANKLE:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	4-6 weeks
Light	4-6 weeks
Medium	6-8 weeks
Heavy	8-12 weeks

ELBOW:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	1-3 weeks
Light	2-6 weeks
Medium	4-8 weeks
Heavy	6-12 weeks

FINGER OR THUMB JOINTS:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	0-1 week
Light	0-2 weeks
Medium	1-4 weeks
Heavy	1-6 weeks

HIP:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	4-8 weeks
Light	4-8 weeks
Medium	6-12 weeks
Heavy	6-14 weeks

JAW:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	0-1 week
Light	0-1 week
Medium	0-1 week
Heavy	0-1 week

KNEE:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	3-12 weeks
Light	8-16 weeks
Medium	12-26 weeks
Heavy	12-26 weeks

PATELLA:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-3 weeks
Light	2-6 weeks
Medium	6-8 weeks
Heavy	6-12 weeks

SHOULDER (glenohumeral) INITIAL DISLOCATION:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-2 weeks
Light	1-3 weeks
Medium	4-8 weeks
Heavy	6-12 weeks

SPONDYLOLISTHESIS (developmental – non-traumatic):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
1. Aggravational – soft tissue only most cases.	If layoff exceeds 4 weeks the recommended recovery time is based on the medical reports and the Medical Advisor's opinion.
2.(a) With disc protrusion treated conservatively.	If layoff exceeds 8 weeks the recommended recovery time is based on the medical reports and the Medical Advisor's opinion.
2.(b) With disc protrusion treated with surgical discectomy.	If layoff exceeds 12 weeks the recommended recovery time is based on the medical reports and the Medical Advisor's opinion.

TOES:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	0-1 week
Light	0-2 weeks
Medium	0-3 weeks
Heavy	0-3 weeks

WRIST (includes distal radio-ulnar joint):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-8 weeks
Light	1-8 weeks
Medium	4-12 weeks
Heavy	6-14 weeks

ACETABULUM:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	10-16 weeks
Light	10-16 weeks
Medium	12-26 weeks
Heavy	16-26 weeks

ANKLE (lateral or medial malleolus):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-3 weeks
Light	1-4 weeks
Medium	4-8 weeks
Heavy	8-16 weeks

ANKLE (bimalleolar):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	2-4 weeks
Light	6-8 weeks
Medium	12-20 weeks
Heavy	12-26 weeks

ANKLE (trimalleolar):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	2-4 weeks
Light	12-16 weeks
Medium	12-26 weeks
Heavy	12-30 weeks

CARPAL BONES INCLUDING SCAPHOID:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-4 weeks
Light	1-8 weeks
Medium	6-12 weeks
Heavy	8-12 weeks

CLAVICLE:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-4 weeks
Light	1-4 weeks
Medium	4-6 weeks
Heavy	6-8 weeks

COCCYX:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-4 weeks
Light	2-4 weeks
Medium	3-6 weeks
Heavy	4-6 weeks

COLLES FRACTURE:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-4 weeks
Light	2-8 weeks
Medium	2-8 weeks
Heavy	8-12 weeks

FEMUR (shaft):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	8-12 weeks
Light	8-16 weeks
Medium	16-20 weeks
Heavy	16-26 weeks

FIBULA (shaft):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-4 weeks
Light	1-4 weeks
Medium	4-6 weeks
Heavy	6-8 weeks

HIP (proximal femur):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	12-16 weeks
Light	12-16 weeks
Medium	12-20 weeks
Heavy	16-26 weeks

HUMERUS:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	3-6 weeks
Light	3-6 weeks
Medium	3-8 weeks
Heavy	6-12 weeks

MAXILLA:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-4 weeks
Light	1-4 weeks
Medium	1-4 weeks
Heavy	1-4 weeks

METACARPAL BONES:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	0-6 weeks
Light	1-6 weeks
Medium	2-8 weeks
Heavy	4-12 weeks

METATARSAL:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	0-2 weeks
Light	4-6 weeks
Medium	6-10 weeks
Heavy	8-12 weeks

NOSE:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	0-1 week
Light	0-1 week
Medium	0-1 week
Heavy	0-1 week

OS CALCIS/CALCANEUM (displaced/intra articular):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	6-12 weeks
Light	8-16 weeks
Medium	12-26 weeks
Heavy	16-52 weeks

OS CALCIS/CALCANEUM (undisplaced):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	4-8 weeks
Light	6-12 weeks
Medium	8-16 weeks
Heavy	8-16 weeks

PATELLA:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	2-8 weeks
Light	2-8 weeks
Medium	4-12 weeks
Heavy	4-16 weeks

PELVIS (not acetabulum):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	2-10 weeks
Light	4-12 weeks
Medium	6-16 weeks
Heavy	8-20 weeks

PHALANGES (HAND):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	0-6 weeks
Light	1-6 weeks
Medium	4-8 weeks
Heavy	6-10 weeks

PHALANGES (FOOT):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	0-1 week
Light	0-2 weeks
Medium	1-4 weeks
Heavy	3-8 weeks

RADIUS:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-4 weeks
Light	2-8 weeks
Medium	4-8 weeks
Heavy	8-12 weeks

RADIUS & ULNA:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-4 weeks
Light	2-8 weeks
Medium	4-8 weeks
Heavy	8-12 weeks

RIBS – Single or Multiple:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	0-3 weeks
Light	1-4 weeks
Medium	2-6 weeks
Heavy	4-8 weeks

SCAPULA:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-4 weeks
Light	1-4 weeks
Medium	4-6 weeks
Heavy	4-10 weeks

SKULL – Compound, Comminuted or Depressed Fracture:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	by report
Light	by report
Medium	by report
Heavy	by report

SKULL – SIMPLE FRACTURE (no brain injury):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	2-4 weeks
Light	2-6 weeks
Medium	4-8 weeks
Heavy	6-10 weeks

STERNUM:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-4 weeks
Light	2-6 weeks
Medium	2-6 weeks
Heavy	4-8 weeks

TALUS (displaced/comminuted):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	2-6 weeks
Light	8-12 weeks
Medium	16-26 weeks
Heavy	20-30 weeks

TALUS (undisplaced):

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	2-4 weeks
Light	4-6 weeks
Medium	6-10 weeks
Heavy	8-12 weeks

TIBIA (shaft):

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	4-6 weeks
Light	6-12 weeks
Medium	8-16 weeks
Heavy	12-26 weeks

ULNA:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	1-4 weeks
Light	2-8 weeks
Medium	4-8 weeks
Heavy	8-12 weeks

VERTEBRAE (spinous process, transverse process only):

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

SINGLE LEVEL FRACTURES

Limited	2-4 weeks
Light	2-4 weeks
Medium	4-6 weeks
Heavy	6-8 weeks

MULTIPLE LEVEL FRACTURES

extend above times an additional two weeks

VERTEBRAL BODY COMPRESSION FRACTURE (stable):

WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

2-8 weeks
2-10 weeks
8-12 weeks
12-16 weeks

BURSITIS:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	0-2 weeks
Light	0-3 weeks
Medium	1-6 weeks
Heavy	1-8 weeks

**Factors which may influence length of disability:

The joint(s) affected may influence the length of disability. In some cases surgery may be required.

CELLULITIS:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	0-2 weeks
Light	0-2 weeks
Medium	0-2 weeks
Heavy	0-2 weeks

CONTUSION (trunk):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	0-1 week
Light	0-2 weeks
Medium	0-3 weeks
Heavy	0-4 weeks

**DISC HERNIATION—CERVICAL
(conservative medical management):**

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	3-6 weeks
Light	3-6 weeks
Medium	4-8 weeks
Heavy	6-16 weeks

DISC HERNIATION-LUMBAR (conservative medical management):WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

3-6 weeks
3-6 weeks
4-12 weeks
6-20 weeks (return to this work level
usually not recommended)

LACERATIONS (superficial):WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

0-2 weeks
0-2 weeks
0-2 weeks
0-2 weeks

LACERATIONS (trunk):WORK CAPABILITIES/WORK REQUIREMENTS

Minor
Major

DISABILITY DURATION

0-2 weeks
3-6 weeks

PHLEBITIS:WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

1-2 weeks
1-2 weeks
1-2 weeks
1-2 weeks

PULMONARY EMBOLUS:WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

2-4 weeks
6-8 weeks
8-12 weeks
8-12 weeks

SUPERFICIAL INJURY (unspecified, e.g., abrasions):

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

All Categories

1 week

TENDONITIS, EPICONDYLITIS (medial/lateral):

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited

0-3 weeks

Light

0-3 weeks

Medium

2-6 weeks

Heavy

6-8 weeks

ACL RECONSTRUCTION (by report):WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Maximum recovery is expected 16 to 20 weeks.

ACROMIO-CLAVICULAR JOINT EXCISION:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	2-4 weeks
Light	4-6 weeks
Medium	6-8 weeks
Heavy	8-12 weeks

ACROMIOPLASTY – SUBACROMIAL DECOMPRESSION (open):WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	2-4 weeks
Light	3-6 weeks
Medium	4-12 weeks
Heavy	6-16 weeks

ACROMIOPLASTY (arthroscopic):WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	1-3 weeks
Light	1-4 weeks
Medium	4-8 weeks
Heavy	6-12 weeks

ARTHROPLASTY – HIP:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	3-6 weeks
Light	6-8 weeks
Medium	8-12 weeks
Heavy	12-26 weeks (return to this level of work is not usually recommended)

ARTHROPLASTY – KNEE:WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

3-6 weeks
6-8 weeks
8-12 weeks
12-26 weeks (return to this level of work is not usually recommended)

ARTHROSCOPY – DIAGNOSTIC (no other procedure):WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

0-1 week
0-1 week
0-2 weeks
0-2 weeks

CARPAL TUNNEL RELEASE (open):WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

1-6 weeks
1-6 weeks
3-8 weeks
3-8 weeks

COCCYGECTOMY:WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

2-4 weeks
3-5 weeks
3-5 weeks
4-6 weeks

DECOMPRESSION LAMINECTOMY:WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

4-8 weeks
6-10 weeks
8-12 weeks
8-16 weeks (return to heavy work may not be recommended)

DISCECTOMY – CERVICAL SPINE (with fusion):

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	6-12 weeks
Light	6-12 weeks
Medium	8-16 weeks
Heavy	12-20 weeks

DISCECTOMY – LUMBAR SPINE:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	4-12 weeks
Light	4-12 weeks
Medium	8-16 weeks
Heavy	12-20 weeks (return to this work level not usually recommended)

DISCECTOMY – THORACIC SPINE:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	4-8 weeks
Light	4-8 weeks
Medium	6-12 weeks
Heavy	8-16 weeks

GANGLION EXCISION:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	1-2 weeks
Light	2-3 weeks
Medium	2-4 weeks
Heavy	2-4 weeks

HERNIA SURGERY:

<u>WORK CAPABILITIES/WORK REQUIREMENTS</u>	<u>DISABILITY DURATION</u>
Limited	4-6 weeks
Light	6-8 weeks
Medium	6-8 weeks
Heavy	6-8 weeks

LATERAL RETINACULAR RELEASE:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	2-4 weeks
Light	4-6 weeks
Medium	6-8 weeks
Heavy	8-12 weeks

MANDIBLE – WIRED:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	1-8 weeks
Light	3-8 weeks
Medium	3-8 weeks
Heavy	6-8 weeks

MENISCECTOMY:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	1-3 weeks
Light	4-6 weeks
Medium	4-8 weeks
Heavy	4-10 weeks

NEUROSTIMULATOR IMPLANTS (insertion):WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited	0-2 weeks
Light	0-2 weeks
Medium	0-2 weeks
Heavy	return to this work not usually recommended
+	

NEUROSTIMULATOR IMPLANTS (removal):WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

all categories	0-1 week
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OSTEOTOMY OF TIBIA:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Maximum recovery is expected 12 to 20 weeks.

PATELLAR TENDON REPAIR (by report):WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Maximum recovery is expected 12-16 weeks.

PATELLAR TENDON TRANSFER (by report):WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Maximum recovery is expected 12-16 weeks.

REMOVAL OF INTERNAL FIXATION DEVICE (e.g., rods, screws):WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

1-3 weeks

ROTATOR CUFF REPAIR:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited
Light
Medium
Heavy

2-4 weeks
3-6 weeks
4-12 weeks
6-20 weeks

SHOULDER REPAIR – SHOULDER DISLOCATION/INSTABILITY:WORK CAPABILITIES/WORK REQUIREMENTSDISABILITY DURATION

Limited
Light
Medium
Heavy

2-4 weeks
3-6 weeks
6-12 weeks
12-16 weeks (unlikely to return to heavy work)

SPINAL FUSION – LUMBAR SPINE:WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

8-16 weeks
10-16 weeks
16-26 weeks
16-52 weeks (return to this work level is not usually recommended)

TALONAVICULAR FUSION:WORK CAPABILITIES/WORK REQUIREMENTS

Maximum recovery is expected 16 to 20 weeks.

DISABILITY DURATION**TENDOLYSIS/TENDON RELEASES:**WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

2-4 weeks
2-4 weeks
3-6 weeks
4-8 weeks

TENDON REPAIRS/TRANSFERS:WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

2-6 weeks
2-8 weeks
6-12 weeks
8-16 weeks

ANKLE:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	0-2 weeks
Light	1-4 weeks
Medium	2-6 weeks
Heavy	2-8 weeks

CERVICAL SPINE:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	0-3 weeks
Light	0-3 weeks
Medium	1-6 weeks
Heavy	1-6 weeks

ELBOW:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	0-2 weeks
Light	0-4 weeks
Medium	2-6 weeks
Heavy	2-8 weeks

FINGER/THUMB:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	0-4 weeks
Light	0-4 weeks
Medium	1-6 weeks
Heavy	1-8 weeks

HIP:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	0-3 weeks
Light	0-3 weeks
Medium	2-6 weeks
Heavy	2-8 weeks

KNEE (collateral ligament):WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

0-2 weeks
0-4 weeks
2-8 weeks
2-12 weeks

KNEE (cruciate ligament):WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

0-4 weeks
2-6 weeks
4-16 weeks
4-16 weeks

LUMBOSACRAL SPINE:WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

0-2 weeks
0-3 weeks
1-4 weeks
1-6 weeks

SACROILIAC:WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

0-2 weeks
0-3 weeks
1-4 weeks
1-6 weeks

SHOULDER (ac; glenohumeral):WORK CAPABILITIES/WORK REQUIREMENTS

Limited
Light
Medium
Heavy

DISABILITY DURATION

0-2 weeks
0-3 weeks
2-6 weeks
4-12 weeks

THORACIC SPINE:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	0-2 weeks
Light	0-3 weeks
Medium	1-4 weeks
Heavy	1-6 weeks

TOES:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	0-1 week
Light	0-1 week
Medium	0-2 weeks
Heavy	0-2 weeks

WRIST:

WORK CAPABILITIES/WORK REQUIREMENTS

DISABILITY DURATION

Limited	0-2 weeks
Light	0-4 weeks
Medium	2-6 weeks
Heavy	2-8 weeks

ACKNOWLEDGEMENTS

These Disability Duration Guidelines were prepared to provide health care professionals and claims adjudicators a common reference regarding workers' absences from the workplace due to illness or injury.

The NWT guidelines were prepared using the *Alberta WCB Disability Duration Guidelines*, *The Medical Disability Advisor – Workplace Guidelines for Disability Duration* (by Dr. P. Reed), and *The Minnesota Medical Association Temporary Disability Duration Guidelines* as references. Clinical experience was drawn from the Medical Advisors at the Workers' Compensation Board of the NWT, Nova Scotia, and several members of the Occupational and Environmental Medical Association of Canada.

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