



101-1500 Notre Dame Ave.
 Winnipeg MB
 R3E 0P9
 Phone: 1-204-772-0425
 Fax: 1-204-775-6829
 Info Line: 1-800-315-3331

Website: www.mahcp.ca

WORKLOAD ASSESSMENT FORM

FACILITY: _____ DEPARTMENT: _____

DATE: _____ TIME: _____

NO. OF STAFF ON DUTY: _____

CIRCUMSTANCES (List all procedures required to be done at this time):

Was extra staff requested? _____

Who authorized/declined request? _____

Was help received? Yes No If yes, hours worked: _____

Working Conditions:

	Yes	No
a) Meal period missed?	<input type="checkbox"/>	<input type="checkbox"/>
b) Rest period missed?	<input type="checkbox"/>	<input type="checkbox"/>
c) Overtime worked?	<input type="checkbox"/>	<input type="checkbox"/>
d) Amount of OT worked _____		
e) Other (please specify) _____		

Contributing factors to situation (list non-routine procedures or orders, applicable special conditions, delays due to patient transportation, work incompleted from previous shift, etc.):

Impact on Patient Care:

Recommendations, Suggestions or Comments:

 Name (please print)

 Signature

 Date