Workload Assessment Form

Name: _____

Facility: _____ Department: _____

Date: _____ Time: _____ # 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?	☐	☐
b) Rest period missed?	☐	☐
c) Overtime worked?	☐	☐
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 in completed from previous shift, etc.):

_____

_____

_____

_____

Impact on Patient Care:

_____

_____

_____

_____

(continues on back of form)

COPY 1: MAHCP OFFICE COPY 2: DEPT. MANAGER COPY 3: STAFF REP

Recommendations, Suggestions or Comments: (please use back of form if needed)

(Additional Space)

Member signature: _____

COPY 1: MAHCP OFFICE COPY 2: DEPT. MANAGER COPY 3: STAFF REP