

**WORKERS' COMPENSATION BOARD  
OF SASKATCHEWAN  
FUNCTIONAL IMPAIRMENT RATING SCHEDULE  
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## **INTRODUCTION:**

The rating schedule employed by the Saskatchewan Workers' Compensation Board is modeled after, and is similar in most respects to the schedules used by other Compensation Boards in Canada. A few minor modifications have been made in consideration of the fact that Saskatchewan has legislation which differs from other provinces.

The rating schedule is designed to recognize impairment of mind and body function of significant magnitude to cause the injured worker to modify his/her activities whether or not it affects his/her earning capacity. In line with the schedules employed by other Workers' Compensation Boards, the stress is on impairment of normal physical activity so that 100% impairment is rated when there is cessation of normal physical activity, rather than when there is cessation of life processes. An injured worker with 100% functional impairment, according to this schedule, might live for many years and could die of some cause unrelated to the compensable impairment.

The evaluation of functional impairment is done by experienced physicians and qualified consultants as determined by the Board who are knowledgeable about mind and body function. The impairment rating process is much too complicated to be described in minute detail, however, it is based on the application of a few simple rules:

1. Awards are given for permanent functional impairment so that treatment must be complete and adequate healing time have elapsed before rating is done.
2. Impairment ratings are never based on the type of injury or the type of surgery performed but are based on demonstrable loss of function after adequate healing time and after adequate treatment has been provided.
3. No award will be given, specifically, for pain and suffering.
4. Cosmetic impairment, of significant degree, might merit an award at the discretion of the Board.
5. Functional impairment resulting from injury to internal organs will be dealt with on the merits of the individual case. In general, no award will be given unless the injury is sufficient to cause the worker to modify his activities, in some fashion. In some cases, for example head injuries, injuries to the heart, circulatory system, and lungs, impairment rating will be done by independent consultants with special knowledge and experience.
6. Ratings for loss of function of an extremity cannot exceed the rating for amputation of the extremity.

7. The rating for loss of function at a joint rarely exceeds one half of the rating for an amputation of the extremity.
8. In this rating schedule, functional impairment will be expressed as a percentage of the total body impairment.
9. With the exception of the special schedule for loss of hearing and loss of vision, the smallest rating to be assigned will be 0.5% total body impairment and the impairment rating will be in multiples of 0.5% for ratings of 10% or less and multiples of 2.5% for rating in excess of 10%. Ratings for loss of hearing and loss of vision will be in multiples of 0.5% whether the rating is below or above 10% total body impairment.
10. Psychological impairment resulting from injury will be assessed on the merits of the individual case and will be based on the recognition of a defined psychiatric disorder.
11. The dollar value of the percentage of functional impairment will be set by legislation and could, conceivably, change from time to time.

## **APPLICATION OF THE SCHEDULE**

### **THE SCHEDULE IS A GUIDE:**

This or any other schedule is at best only a guide, to be departed from when the occasion demands.

### **JUDGEMENT RATINGS:**

A great many cases will not fit neatly into a rating schedule. In these cases, the schedule will be used as a guide and the examining physician will use his/her judgment to estimate the percentage of total body impairment. The rating that is used should be consistent with ratings for impairment of other parts of the body which, in the average person, would have a similar effect on activities.

### **ENHANCEMENT OF MULTIPLE INJURIES:**

In multiple injuries, or in serial injuries, the impairment rating must sometimes be enhanced in order to accurately reflect the effect of the injury on the individual's activities. This is true when injuries involve parts of the body which perform identical functions, e.g. both arms, both legs, both eyes, etc. Ordinarily, there would be no enhancement factor between a hand and a foot, a foot and an eye, etc. An enhancement of up to 50% of the lesser impairment might be warranted in injuries of both arms or both legs, but care must be taken that the sum of the two individual ratings plus the added enhancement is not disproportionate when applied to the whole person.

Enhancement is particularly important when dealing with finger injuries, therefore, the enhancement is built into the finger injury rating schedule, as well as the schedules for loss of hearing and vision.

### **AMPUTATIONS:**

The scheduled ratings for amputations compensate for loss of tissue, however, in addition, the functional and cosmetic result must be considered. The ratings given are applicable for "average" stumps suitably padded and sufficiently pain free to be functional. For an amputation with an average result, the schedules rating covers the cosmetic aspect of the amputation.

**SCOPE OF THE SCHEDULE:**

The following schedule includes the types of impairment involved in the vast majority of compensation claims. When implementing the schedule, the medial examiner will employ judgment, taking into consideration such factors as loss of sensation, impaired circulation, muscular weakness, and loss of range of movement in the affected part.

When dealing with a type of functional impairment not covered in this schedule, the advice of an appropriate authority should be sought concerning the rating. AMA GUIDES TO THE EVALUATION OF PERMANENT IMPAIRMENT can be used as a reference but it must be remembered that these guides are prepared for the type of compensation law in use in the United States rather than in Canada. The impairment rating that is decided upon should be consistent with the ratings elsewhere in this schedule.

**INJURY TO BRAIN, SPINAL CORD, AND PERIPHERAL NERVES**

**BRAIN AND SPINAL CORD:**

Quadriplegia -----	100%
Paraplegia -----	100%
Paraparesis - rated on loss of function	
Hemiplegia -----	100%
Hemiparesis - rated on loss of function	
Diffuse injury to brain and/or spinal cord - rated on loss of body function	

**DENERVATION:**

Peroneal nerve, complete -----	12.5%
Median nerve, complete at elbow -----	40%
Median nerve, complete at wrist -----	20%
Ulnar nerve, complete at elbow -----	10%
Ulnar nerve, complete at wrist -----	8%

**IMPAIRMENT OF SPECIAL SENSES****SENSE OF SMELL:**

Complete loss of sense of smell (including impairment of sense of taste) ----- 3%

**LOSS OF VISION:**

Enucleation of one eye ----- 18%

Total loss of vision, one eye ----- 16%

Lens replacement, cataract or aphakia will be rated at 5%  
Or the visual acuity of the eye, whichever is greatest----- 5%

Bilateral lens replacement, cataract or aphakia will be rated  
at 10% or the visual acuity, whichever is the greatest----- 10%

Hemianopsia, right field ----- 25%

Hemianopsia, left field ----- 20%

Diplopia, all fields ----- 10%

Scotoma, depending on location and extent ----- 0-16%

Total loss of vision, both eyes ----- 100%

**PARTIAL LOSS OF VISION:**

Best Corrected Vision 20/30 ----- 0%

Best Corrected Vision 20/40 ----- 1%

Best Corrected Vision 20/50 ----- 2%

Best Corrected Vision 20/60 ----- 4%

Best Corrected Vision 20/80 ----- 6%

Best Corrected Vision 20/100 ----- 8%

Best Corrected Vision 20/200 ----- 14%

Best Corrected Vision 20/400 ----- 16%

Partial loss of vision in both eyes will be calculated according to the above schedule  
Employing an enhancement factor of 84/16 for the better eye, i.e., the poorer eye is  
rated according to the above schedule and the better eye is rates according to the same  
schedule but multiplied by 84/16 and the sum of the two gives the combined rating.

**LOSS OF SENSE OF HEARING:**

When calculating impairment due to loss of hearing, the ISO audiometric calibration will be used and the hearing loss will be averaged at 500, 1000, 2000, and 3000 hertz. No presbycusis factor will be deducted.

In order to merit an award, there must be an average hearing loss of at least 30 decibels in one ear. A hearing loss averaging 80 decibels is considered to be total loss of hearing in that ear.

Deafness, complete one ear -----	5%
Deafness, complete both ears -----	30%
Deafness, complete both ears occurring as a sudden and complete traumatic loss of hearing -----	60%

**TINNITUS:**

In cases of longstanding distressing tinnitus, an additional rating of up to 5% total body impairment may be added. Tinnitus is a subjective experience for which there is no objective measurement. In order to merit an award, the rating physician must be convinced that the tinnitus has been continuous for at least 2 years and that it is distressing to the claimant. If it is distressing, it is almost certain that the attending physician, the consultant otolaryngologist, and the audiologist will have mentioned it in their reports. It is extremely rare for tinnitus due to either direct trauma or acoustic trauma to be sufficiently distressing to warrant a 5% rating.

**UNILATERAL HEARING LOSS:**

When dealing with unilateral hearing loss the cause of impairment is due to loss of stereococsis. For partial, unilateral hearing loss, therefore, the average hearing loss in the unaffected ear is subtracted from the average hearing loss in the affected ear and the difference determines the impairment rating.

Difference of 30 - 39 dbs -----	1%
Difference of 40 - 49 dbs -----	2%
Difference of 50 - 59 dbs -----	3%
Difference of 60 - 69 dbs -----	4%
Difference of 70 dbs or greater -----	5%

**BILATERAL, PARTIAL HEARING LOSS:**

35 dbs, in single ear -----	0.4%
40 dbs, in single ear -----	0.7%
45 dbs, in single ear -----	1.0%
50 dbs, in single ear -----	1.4%
55 dbs, in single ear -----	1.8%
60 dbs, in single ear -----	2.3%
65 dbs, in single ear -----	2.8%
70 dbs, in single ear -----	3.4%
75 dbs, in single ear -----	4.0%
80 dbs, in single ear -----	5.0%

In calculating the impairment for a bilateral hearing loss, the poorer ear is rated according to the above scale, better ear according to the same scale but multiplied by 5. The sum of the two gives the combined rating.

## IMPAIRED FUNCTION OF ARM

### JUDGEMENT RATINGS:

While loss of tissue and loss of range of movement at a joint is readily measured and easily rated in impairment rating schedules, circulation, sensation, and muscle power are equally important. Especially when dealing with fingers, sensation is of utmost importance to the extent that a digit with complete loss of sensation results in impairment approaching the impairment caused by amputation. Similarly, with impaired circulation and muscle power.

### AMPUTATIONS:

Proximal third of humerus or disarticulation at shoulder -----	70%
Middle third of humerus -----	65%
Distal third of humerus to biceps insertion -----	60%
Biceps insertion to wrist (depending on usefulness of stump) -----	50-60%
Total amputation of hand -----	50%
Thumb, including first metacarpal -----	20%
Thumb, at MP joint -----	15%
Thumb, at IP joint -----	10%
Thumb, one-half distal phalanx -----	5%
Thumb, at least one quarter of distal phalanx -----	2.5%

**FINGER AMPUTATIONS:**

Amputations of less than one half of the distal phalanx, with acceptable stump, will, ordinarily, warrant no rating.

Corrective shaping of the head of the next phalanx or metacarpal, done to improve the shape of the stump, does not increase the rating.

The following table contains built-in enhancement for multiple finger injuries.

The enhancement factors are as follows:

For two finger loss, value is 1.5 x single finger value.

For three finger loss, value is 2 x single finger value.

For four finger loss, value is 3 x single finger value.

**FINGER AMPUTATIONS:**

Fingers, all four-----	35%
Fingers, all four at PIP-----	28%
Fingers, all four at DIP -----	14%
Finger, index-----	5%
Finger, index at PIP-----	4%
Finger, index at DIP-----	2%
Finger, middle -----	4%
Finger, middle at PIP -----	3.2%
Finger, middle at DIP -----	1.6%
Finger, ring -----	3%
Finger, ring at PIP -----	2.4%
Finger, ring at DIP-----	1.2%
Finger, little-----	2%
Finger, little at PIP -----	1.6%
Finger, little at DIP -----	0.8%

**Metacarpals – add value of proximal phalanx**

Fingers, index, middle and ring -----	24%
Fingers, index, middle and little -----	22%
Fingers, middle, ring and little -----	18%
Fingers, index and middle -----	13.5%
Fingers, index and ring-----	12%
Fingers, index and little -----	10.5%
Fingers, middle and ring-----	10.5%
Fingers, middle and little-----	9%
Fingers, ring and little-----	7.5%

**IMPAIRMENT OF MOBILITY IN ARM:**

Shoulder, ankylosed without either articular or scapular movement-----	35%
Elbow, completely ankylosed in position of function -----	20%
Wrist, completely ankylosed in position of function -----	12.5%
Pronation and supination, complete immobility of mid position -----	10%
Thumb, both joints ankylosed in position of function -----	7.5%
Thumb, distal joint ankylosed in position of function -----	5%

**FINGERS:**

Fingers will be rated according to the amputation values. When a finger joint is fused in the position of ideal function, the rating is one half of what it would be for an amputation at that level. If a joint is fused in a position that is not ideal, and there is some good reason why surgical correction will not be done, the rating could equal up to the rating for amputation at that joint.

**PARTIAL LOSS OF MOVEMENT:** The impairment rating for partial loss of movement will be proportional to the amount of movement that is lost. In as much as there are great variations from person to person in ranges of movement, when there is a completely normal extremity to compare with, loss of movement can be determined by comparing the movement in the joint being examined with the movement in the normal joint on the opposite extremity.

When there is not a normal extremity to compare with, the following will be considered to be normal ranges of movement for arm joints:

<b>Shoulder:</b>	Forward Elevation - 150?
	Backward Elevation - 40?
	Abduction - 150?
	Adduction - 30?
	Internal Rotation - 40?
	External rotation - 90?

<b>Elbow:</b>	Flexion-extension 150
<b>Forearm:</b>	Pronation - 80? Supination - 80?
<b>Wrist:</b>	Dorsiflexion – 60 ? Palmar Flexion - 70? Radial Deviation - 20? Ulnar Deviation - 20?
<b>Thumb :</b>	MP Joint – 60 ? IP Joint - 80? (Abduction and adduction vary greatly from person to person)
<b>Fingers:</b>	MP Joint - 90? PIP Joint - 100? DIP Joint - 70?

PARTIAL LOSS OF MOVEMENT OF FINGERS:

For partial loss of movement at a joint, the lost range of movement in degrees, is divided by the normal range of movement and multiplied by one half of the amputation rating at that joint. If there has been an amputation at a point distal to the joint, only the values of the retrained phalanx or phalanges are employed in the calculation for loss of movement.

## IMPAIRED FUNCTION OF LEG

### AMPUTATIONS:

The scheduled ratings assigned to major amputations of the lower extremity assume that the amputation stump is suitable for weightbearing prosthesis. Generally, the stump must be well padded and the scar properly placed. There should not be undue tenderness over areas that are subject to pressure. When stump defects exist which cannot be remedied, a rating greater than that shown in the schedule might be necessary.

### AMPUTATION RATINGS:

Hip - disarticulation or short stump requiring ischial bearing prosthesis -----	65%
Thigh, seat of election -----	50%
End bearing or short below-knee stump not suitable for conventional B.K. prosthesis -----	45%
Leg, suitable for B.K. prosthesis -----	35%
Leg, at ankle, end bearing -----	25%
Through foot -----	10-25%
Great toe, both phalanges -----	5%
Great toe, distal phalanx -----	2.5%
Other toes, total amputation, each -----	0.5%
All toes, total amputation -----	7.5%
<b><u>LOSS OF MOBILITY OF LEG JOINTS:</u></b>	
Hip, fused in acceptable position -----	30%
Knee, fused in acceptable position -----	25%
Ankle, fused in acceptable position -----	15%
Triple arthrodesis -----	5-12.5%
Subtalar arthrodesis -----	0-10%
Great toe, fusion both joints -----	2.5%
Great toe, fusion distal joint -----	0.5%

**SHORTENING OF THE LEG:**

1 inch (2.5 cm) -----	1.5%
1 ½ inches (4 cm) -----	3%
2 inches (5 cm) -----	6%
3 inches (7.5 cm) -----	15%

## **IMPAIRED FUNCTION OF THE SPINE**

### **INTRODUCTION:**

The assessment of functional impairment due to spinal disease is primarily a judgment rating. Pain is the chief limiting factor due to spinal disease, and there is a great deal of variation between individuals in their response to pain. While there is no foolproof method of assessing pain, one can, through experience, use objective observations which are of assistance in evaluating the effect of pain. Such factors as muscle spasm, limitation of movement ranges, muscle wasting, etc., should be taken into consideration.

In order to warrant a rating, the compensable spinal disease must result in some modification of activities. Intermittent symptoms that do not stop the individual from engaging in normal activities will not warrant an award. Intermittent symptoms which are sufficiently frequent or sufficiently severe to cause an individual to avoid certain normal activities such as heavy lifting, will warrant an impairment rating. Since these are largely judgment ratings, the lowest rating for spinal disease will be 2.5% total body impairment and all other ratings will be in multiples of 2.5%.

Spinal symptoms during the acute phase can be totally disabling, however, there are very few cases that can warrant a 100% impairment rating after adequate treatment. Theoretically, the "average" person earns half of his living by physical activity and half by mental activity. The individual with severe spinal disease, who would be physically capable of traveling to the work place, would justify a rating of up to 50% total body impairment.

Because of the amount of judgment involved in rating impairment due to spinal disease, a rigid rating schedule is not possible. The following can be used as a guide. It is most important that consistency of rating be achieved.

## IMPAIRMENT RATING GUIDE FOR SPINAL DISEASE

<u>SYMPTOMS</u>	<u>SIGNS</u>	<u>RATING</u>
<b>CERVICAL SPINE:</b>		
Intermittent neck pain. No referred symptoms. Intermittent restriction of activity but able to work full time.	Minor loss of movement. No muscular pain.	0 – 5%
Neck pain. Intermittent referred shoulder/arm pain. Able to work full time with avoidance of extremely heavy lifting.	Moderate loss of movement. Some flattening of lordotic curve. No nerve root signs.	5 – 10%
Persistent neck pain. Referred pain. Avoidance of extremely heavy exertion of neck.	Moderate severe loss of movement. Muscular spasm Motor and sensory neurological changes.	10 – 20%
<b>THORACIC SPINE:</b>		
Persisting mild back pain or pain on respiration. Avoidance of extremely heavy exertion.	Minor loss of movement. No neurological signs.	0 – 5%
Moderate back pain. Intermittent avoidance of moderate activity.	Moderate loss of movement. No neurological signs.	5 – 10%
Moderate to severe back pain with referred pain. Avoidance of moderately strenuous activity.	Moderate to severe loss of movement. Paravertebral muscle spasm.	10 – 20%

**SYMPTOMS****SIGNS****RATING****LUMBAR SPINE:**

Mild, intermittent low back pain. Intermittent restriction of strenuous activity. No referred pain.

Mild loss of movement. No spasm. No neurological signs.

0 – 5%

Mild to moderate low back pain. Intermittent referred pain. Able to work full time but avoid extremely heavy lifting.

Moderate loss of movement  
No persistent muscle spasm.  
Only minor neurological changes (i.e. sensory).

5 – 10%

Moderate to severe low back pain. Might have referred pain. Avoids moderately heavy lifting.

Moderate to severe loss of movement. Intermittent muscle spasm Mild to moderate neurological changes.

10 – 20%

Severe low back pain and/or constant referred pain. Weakness in lower extremities. Avoids all strenuous lifting, bending and twisting.

Severe restrictions of movement. Persisting muscular spasm. Moderate to severe neurological changes including muscle wasting and weakness.

20 – 50%

**PSYCHOLOGICAL IMPAIRMENT:**

It will have been determined that the compensable psychological injury is chronic and unlikely to improve. A qualified Psychologist or Psychiatrist will have performed an evaluation of permanent functional impairment based on the appropriate chapter in the AMA's "Guide to the Evaluation of Permanent Functional Impairment". Based on that evaluation and the judgment of the WCB Medical Officer utilizing the following guidelines, a percent of total body impairment will be applied.

1. Psychological permanent impairment will be rated according to the attached *Classification for Assessing Mental Impairment*.
2. The impairment related to a body part covered elsewhere in this schedule is rated using the procedures presented in that section.
3. A pre-injury profile of the worker's mental, behavioral and physical status should be obtained if not available from review of the case history.
4. Because this rating schedule does not give consideration to symptoms of pain and suffering or mental and behavioral disorders when assessing permanent functional impairment to body parts included in the schedule, then the mental impairment will be considered a separate impairment independent of physical injury and will be added to any physical impairment.

**CLASSIFICATION FOR ASSESSING MENTAL IMPAIRMENT:****CLASS I - NO IMPAIRMENT      0%**

The worker:

- i. is able to carry on with all of the activities of daily living, and
- ii. is able to perform work related duties without difficulty under normal conditions of stress, or
- iii. may exhibit intermittent pain behavior without restriction of functional ability.

**When evaluating a pre-existing mental condition**, in addition to confirmation of the above, the work history does not reveal any time loss due to the condition.

**CLASS II - MINIMAL IMPAIRMENT      1% - 10%**

The worker:

- i. is able to carry out all of the activities of daily living with some decrease in personal and social efficiency, and
- ii. exhibits mild anxiety in the form of restlessness, uneasiness and tension which result in minimal functional limitation, or
- iii. exhibits pain behavior causing a minimal restriction of functional ability, and
- iv. is able to function in most vocational settings but develops secondary psychogenic symptoms under normal conditions of stress.

**When evaluating a pre-existing mental condition**, in addition to confirmation of the above, a work history will reveal occasional time loss due to the condition (less than 10 working days in the 12 months preceding the work related accident).

**CLASS III - MILD IMPAIRMENT****11% - 30%**

The worker:

- i. is capable of taking care of all personal needs at home but may experience a reduced confidence level and an increased dependency outside the home, and
- ii. experiences a definite limitation of personal and social efficiency, or
- iii. suffers episodic anxiety, agitation and unusual fear of situations which appear to threaten re-injury, or
- iv. exhibits persistent pain behavior, associated with signs of emotional withdrawal and depression (e.g., loss of appetite, insomnia, chronic fatigue, low noise tolerance and mild psychomotor retardation), or
- v. in the case of conversion reactions, consistently avoids the use of the affected part leading to restriction of everyday activities, and
- vi. will probably require vocational adjustment depending upon both the signs and symptoms present and the nature of the pre-accident work.

**When evaluating a pre-existing mental condition**, in addition to confirmation of the above, a work history will reveal frequent time loss due to the condition (11-20 working days in the 12 months preceding the work related accident).

**CLASS IV - MODERATE IMPAIRMENT            31% - 50%**

The worker:

- i.        suffers definite deterioration of familial adjustment and incipient breakdown of social integration, and
- ii.        experiences long episodes of depression evidenced by a withdrawal from family and society and significant intolerance of noise and stress, or
- iii.        in the case of conversion reactions, exhibits bizarre behavior and a tendency to avoid anxiety creating situations to the point of significant restriction of everyday activities, and
- iv.        may require periodic confinement to the home or a treatment facility and will need significant vocational adjustment.

**When evaluating a pre-existing mental condition**, in addition to confirmation of the above, a work history will reveal extensive time loss due to the condition (more than one month in the 12 months preceding the work related accident).

**CLASS V - SEVERE IMPAIRMENT      51% - 75%**

The worker:

- i. exhibits a chronic and severe inability to function both in and out of the home, and
- ii. exhibits evidence of major forgetfulness, lack of concentration and a neglect of personal hygiene, or
- iii. suffers obvious loss of interest in the environment, extreme emotional irritability, emotional lability and uncontrolled outburst of temper, or
- iv. experiences mood changes with psychotic levels of depression, severe motor retardation and psychological regression, and
- v. requires constant supervision and/or confinement as well as major vocational adjustment.

**When evaluating a pre-existing mental condition**, in addition to confirmation of the above, a work history reveals extensive time loss due to the condition (more than 6 months in the 12 months preceding the work related accident).

## **TIMING OF PERMANENT IMPAIRMENT ASSESSMENT**

As indicated previously, adequate time must be allowed to elapse after injury so that treatment is complete and adequate healing time has occurred before assessment of permanent functional impairment can be done.

In a few cases, the rating will be so obvious that no examination will be required and the award for functional impairment can be set at any time. Examples of this are severe brain injury without hope of recovery, quadriplegia, paraplegia and hemiplegia.

In the case of eye injury resulting in enucleation of the eye or obvious total permanent loss of vision of an eye, the award for permanent partial functional impairment can be given early.

In the case of a single finger injury, where it is evident that there will be measurable permanent partial functional impairment of sufficiently minor degree that examination in the Board office is not anticipated, the award can be given when the worker is fit to resume work.

In the case of cosmetic impairment, adequate healing time must be allowed following treatment. For cosmetic impairment due to lacerations or minor burns, at least one year should elapse following surgery and in the case of severe or multiple burns, at least two years should elapse after injury and at least one year after the most recent surgery.

In the case of Psychological injury it should be determined that the current mental function is unlikely to improve and has stabilized with the use of current therapies. Sufficient time should have elapsed since the initial injury to make this determination and should not be less than two years.

The following are the minimum time intervals that should be allowed to elapse prior to permanent partial functional impairment examination, following injury or surgery whichever is the most recent:

<b>INJURY</b>	<b>TIME INTERVAL</b>
Head Injuries -----	2 years
Major Nerve Injuries -----	2 years
Back Injuries -----	1 year
Pelvic Fractures -----	18 months
Intra-abdominal Injuries -----	6 months
Psychological Injuries -----	2 years
Single Digit Injuries -----	6 months
Multiple Digit Injuries -----	1 year
Gross Hand Injuries -----	1 year
Colles' Fractures -----	1 year
Forearm Fractures -----	1 year
Elbow Fractures -----	1 year
Humeral Shaft Fractures -----	1 year
Shoulder Injuries -----	18 months
Amputation of Toes -----	6 months
Serious Injuries to Toes and Forefoot -----	1 year
Os Calcis Fractures -----	18 months

Ankle Fractures -----	18 months
Tibia and Fibula Fractures -----	18 months
Injury Involving Knee Joint -----	1 year
Fractures of Femur -----	1 year
Major Limb Amputations -----	3 months after satisfactory fitting of the prosthesis
Corneal Scars and Ulcers -----	1 year from end of treatment
Retinal Detachment and Major Eye Injuries -----	1 year
Diplopia, Hemianopsia, Field Defect -----	1 year
Trauma to Ear Including Traumatic Deafness -----	6 months
Noise Deafness (Acoustic Trauma)-----	as soon as medical Investigation is complete