

INSTRUCTIONS: This form shall be developed jointly by the employer and the employee and is intended to describe the employee's job duties. The completed form will be reviewed by the treating doctor to determine whether the employee is able to return to his/her job. This is an important document and should accurately show the requirements of the employee's job. If the employee needs help in completing this form, the employee may contact the Information and Assistance Officer at the Division of Worker's Compensation. The phone number can be found in the State Government section of the phone book.

Employee Name: _____
 (Last) (First) (M.I.) Claim Number

Employer Name: _____ **Job Address:** _____

Job Title: _____ **Hours worked per day:** _____ **Hours worked per week:** _____

Description of Job Responsibilities (describe all duties):

1. Check the frequency of activity required of the employee to perform the job.

ACTIVITY (Hours per day)	NEVER 0 hours	OCCASIONALLY up to 3 hours	FREQUENTLY 3-6 hours	CONSTANTLY 6-8+ hours
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending (neck)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending (waist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting (neck)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting (waist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand Use: Dominant Hand Rt. <input type="checkbox"/> Lft. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In repetitive use of hand required?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simple Grasping (right hand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simple Grasping (left hand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Power Grasping (right hand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Power Grasping (left hand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Manipulation (right hand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Manipulation (left hand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing & Pulling (right hand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushing & Pulling (left hand)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching (above shoulder level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching (below shoulder level)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Please indicate the daily Lifting and Carrying requirements of the job:
 Indicate the height the object is lifted from the floor, table or overhead location and the distance the object is carried.

	LIFTING					CARRYING				
	Never 0 hrs.	Occasionally up to 3 hrs.	Frequently 3-6 hrs.	Constantly 6-8+ hours	Height	Never 0 hrs.	Occasionally up to 3 hrs.	Frequently 3-6 hrs.	Constantly 6-8+ hours	Distance
0-10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11-25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51-75 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76-100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100+ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe the heaviest item required to carry and the distance to be carried: _____

3. Please indicate if your job requires any of the following:

	Yes	No	(If Yes, Please Briefly Describe)
a. Driving cars, trucks, forklifts and other equipment?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Working around equipment and machinery?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Walking on uneven ground?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Exposure to excessive noise?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Exposure to extremes in temperature, humidity or wetness?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Exposure to dust, gas, fumes, or chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Working at heights?	<input type="checkbox"/>	<input type="checkbox"/>	
h. Operation of foot controls or repetitive foot movement?	<input type="checkbox"/>	<input type="checkbox"/>	
i. Use of special visual or auditory protective equipment?	<input type="checkbox"/>	<input type="checkbox"/>	
j. Working with bio-hazards such as: bloodborne pathogens, sewage, hospital waste, etc.	<input type="checkbox"/>	<input type="checkbox"/>	

Company Logo

Description of Employee's Job Duties

Employee Comments: _____

Employer Comments: _____

Employer Contact Name: _____ **Employer Contact Title:** _____

Employer Representative Signature: _____ **Date:** _____

Employee's Signature: _____ **Date:** _____

Qualified Rehab. Representative Signature: _____ **Date:** _____
(if applicable)