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## LIGHT DUTY JOB ANALYSIS / ESSENTIAL DEMANDS

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Department: \_\_\_\_\_

Job Title: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Claim No.: \_\_\_\_\_

Supervisor (Name & Title): \_\_\_\_\_

Purpose of Department Work: \_\_\_\_\_

Essential Job Functions (machines, tool and equipment used): \_\_\_\_\_

\_\_\_\_\_

Work Shift: \_\_\_\_\_ Days per week: \_\_\_\_\_

Overtime: \_\_\_\_\_ Location (City): \_\_\_\_\_

### WORK POSTURE REQUIREMENTS

	N/A	1-25%	25-49%	50-74%	75-100%
Sitting	_____	_____	_____	_____	_____
Standing	_____	_____	_____	_____	_____
Walking	_____	_____	_____	_____	_____
Driving	_____	_____	_____	_____	_____
Bending (at waist)	_____	_____	_____	_____	_____
Crouching (squat)	_____	_____	_____	_____	_____
Kneeling	_____	_____	_____	_____	_____
Crawling	_____	_____	_____	_____	_____
Climbing	_____	_____	_____	_____	_____
Twisting	_____	_____	_____	_____	_____
Reaching	_____	_____	_____	_____	_____
Balancing	_____	_____	_____	_____	_____
Throwing	_____	_____	_____	_____	_____
Stretching	_____	_____	_____	_____	_____
Wrist Motion (repetition, flexion / rotation)	_____	_____	_____	_____	_____

Feet (foot pedals) \_\_\_\_\_

### CARRYING REQUIREMENTS

Items Carried: \_\_\_\_\_

Distance: \_\_\_\_\_ Times per Day: \_\_\_\_\_

How Carried: \_\_\_\_\_

Average Weight Carried: \_\_\_\_\_ # Times per Day: \_\_\_\_\_

Maximum Weight Carried: \_\_\_\_\_ # Times per Day: \_\_\_\_\_

Items Carried on Person: \_\_\_\_\_

### LIFTING REQUIREMENTS

Items Lifted: \_\_\_\_\_ Times per Day: \_\_\_\_\_

Average Weight Lifted: \_\_\_\_\_ # Times per Day: \_\_\_\_\_

Maximum Weight Lifted: \_\_\_\_\_ # Times per Day: \_\_\_\_\_

### LIFTING LEVELS / HEIGHTS

Floor      Knee      Waist      Chest      Overhead      Times per Day \_\_\_\_\_

The heaviest weight lifted while either sitting or standing in one place weighs: \_\_\_\_\_ #

And the object's name is: \_\_\_\_\_.

### PUSH / PULL REQUIREMENTS

Items Pushed: \_\_\_\_\_ Items Pulled: \_\_\_\_\_

Times per Day: \_\_\_\_\_ Times per Day: \_\_\_\_\_

### ENVIRONMENTAL CONDITIONS

Inside / Outside	Power Equipment	Ventilation (good / poor)
Hot / Cold Temperatures	Electrical Hazard	Traffic Hazard
Wet	Chemical Hazard	Explosives
Humid	Noise	Stand on Concrete
Cramped Quarters	Vibration	Walk on Uneven Surfaces
Heights	Fumes / Odors	Dust
Moving Objects	Other	Works with Others / Alone

Will you be able to provide modified or alternative work to the injured worker?

Yes \_\_\_\_\_ No \_\_\_\_\_

Define proposed job description: \_\_\_\_\_

\_\_\_\_\_

**We will provide you with limitations and restrictions upon release from the treating physician.**

\_\_\_\_\_  
**Name of person completing this information sheet**

\_\_\_\_\_  
**Date this form was completed**