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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					
Crouching					
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**