DESCRIPTION OF EMPLOYEES JOB DUTIES

THIS FORM PERTAINS ONLY TO JOB AT TIME OF INJURY!!!!!!!!!!

NAME: _____

Employer at the time of the injury: _____
Occupation at the time of injury: _____
List when you began and when you stopped working for the above company:

From: _____ To: _____

Hours per day _____ Days per week _____ Overtime _____

PHYSICAL REQUIREMENTS

Circle one for each requirement:

STAND:	Constant	Frequent	Occasionally	Not at all
WALK:	Constant	Frequent	Occasionally	Not at all
CLIMB:	Constant	Frequent	Occasionally	Not at all
SQUAT:	Constant	Frequent	Occasionally	Not at all
KNEEL:	Constant	Frequent	Occasionally	Not at all
SIT:	Constant	Frequent	Occasionally	Not at all
TWIST:	Constant	Frequent	Occasionally	Not at all
BEND:	Constant	Frequent	Occasionally	Not at all
PUSH:	Constant	Frequent	Occasionally	Not at all
PULL:	Constant	Frequent	Occasionally	Not at all
GRASP:	Constant	Frequent	Occasionally	Not at all
GRIP:	Constant	Frequent	Occasionally	Not at all
REACH:	Constant	Frequent	Occasionally	Not at all
OVERHEAD WORK:	Constant	Frequent	Occasionally	Not at all
TYPE/DATA INPUT:	Constant	Frequent	Occasionally	Not at all
WRITING:	Constant	Frequent	Occasionally	Not at all

Job Description

Heaviest item lifted at work: Circle one

10 lbs 10-25 lbs 25-40 lbs 40-60 lbs 60-80 lbs 80-100 lbs 100+ lbs

Does the job require use of your feet to operate foot controls or for repetitive movement?
YES NO

Does the job require you to work with or in:

Driving cars, trucks, forklifts or other moving equipment? YES NO

Working near hazardous equipment and machinery? YES NO

Walking on uneven ground? YES NO

Exposure to dust, gas or fumes? YES NO

Exposure to noise? YES NO

Exposure to extremes in temperature or humidity? YES NO

Work at heights of _____ feet?

Please provide a brief description of your job responsibilities at the time of the injury:

_____

_____

_____