EMPLOYEE: _______________________________________ SSN: ______________________________

JOB TITLE: ____

PHYSICAL DEMANDS OF JOB:		30 – 1 hr	1hr-21/2hr	21/2-5hr	5-8 hr
LIFTING:	Never	Rarely	Occas.	Freq.	Cont.
	0	1 – 5	6 – 33	34 – 66	67 – 100

Sedentary: up to 10#
Light: 10 – 20
Medium: 20 – 50#
Heavy: 50 – 100#
Very Heavy: 100+#

CARRYING:
Sedentary: up to 10#
Light: 10 – 20#
Medium: 20 – 50#
Heavy: 50 – 100#
Very Heavy: 100+#

STANDING:

WALKING:

SITTING:

PUSHING/PULLING:

CLIMBING:

KNEELING:

CRAWLING:

STOOPING/BENDING:

TWISTING:

GRASPING:

FINGERING:

REACHING:

DRIVING:

ENVIRONMENTAL HAZARDS:

Moving parts:	Dampness:
Electrical shock:	Heat:
High, Exposed Places:	Cold:
Radiant energy:	Gases:
Toxic chemicals:	Noise:
Fumes:	Dust:

PHYSICAL DESCRIPTION OF WORK SITE:

____
____
____
____

SUMMARY JOB DESCRIPTION: IF SO, WHY?

____
____
____
____

IS JOB MODIFIABLE? YES/NO IF SO, WHY?

____
____
____
____

RECOMMENDATION AFTER JOB ANALYSIS:

____
____
____

HRM APPROVAL: ___________________________________ ___________________
Date

TITLE: ____

_____ As recommended. ______ With the following modifications:

****

I concur that the above accurately describes the physical demands of my position duties.
Employee: ____________________________ Date: ______________________

****

Based upon the information provided in this Job Analysis, I feel it is within the patient's ability to perform these duties.

_______________________________ _______________________
PHYSICIAN'S SIGNATURE DATE

I do not feel that the patient is able to perform the duties of this position because of the following reasons:

____
____
____
____

______________________________ ___________________
PHYSICIAN'S SIGNATURE DATE

ADA/VRA:1/97