Occupational On-Site Analysis

EMPLOYEE	SSN or WID	DATE OF INJURY	DATE OF ANALYSIS	CLAIM NUMBER
EMPLOYER	1. Title of job reviewed		Date of hire	Date began job
2. Training required to perform duties (number of)	Days	Weeks	Months	Years
3. Work hours to	First break to	Meal time to	Last Break to	Other

Overtime hrs per week	How often? ☐ Weekly ☐ Monthly ☐ Other ________________________	Any work restrictions when hired? ☐ No ☐ Yes If yes, please specify: ___________________________________

4. General description of job:

5. Types of machines, tools, office equipment, and other special equipment used in job:

6. Vehicles or moving equipment driven as part of job:

7. In an 8 or 12 hour work day, employee can (check number of hours full capacity for each activity).

a. Sit	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	☐ 11	☐ 12
b. Stand	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	☐ 11	☐ 12
c. Walk	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	☐ 11	☐ 12

Comments: (If appropriate, note frequency per hour or day)	8. Employee works (total must = 100%)	Inside percent	Outside percent

9. While performing job, employee is required to: (check one)	Not at All	Occasionally	Frequently	Continuously
a. Twist	☐	☐	☐	☐
b. Bend/Stoop (lumbar)	☐	☐	☐	☐
c. Cervical Bend	☐	☐	☐	☐
d. Squat	☐	☐	☐	☐
e. Crawl	☐	☐	☐	☐
f. Climb Ladders	☐	☐	☐	☐
g. Climb Stairs	☐	☐	☐	☐
h. Reach Above Shoulder Level	☐	☐	☐	☐
i. Crouch	☐	☐	☐	☐
j. Kneel	☐	☐	☐	☐
k. Balance	☐	☐	☐	☐
l. Walk on Uneven Ground	☐	☐	☐	☐
m. Work Above Ground	☐	☐	☐	☐
n. Other: ______________________	☐	☐	☐	☐

10. The heaviest weight lifted while either sitting or standing in one place weighs ___________ . The object's name is __________________ and the estimated times lifted daily is __________ .

11. The heaviest weight carried while walking from place to place weighs __________ . The object's name is _________________________ and the estimated times carried daily is ____________ .

12. The heaviest weight pushed/pulled lbs. of resistance _______________ . The object's name is _________________________ and it is pushed/pulled a distance of ___________ feet at a frequency of _______ # of times per hour _________ per day ______________

13. Physical activity required

	Never	Less than 1	1-2	3-4	5-6	7-8	9-10	11-12
	Total hours performed daily		Frequency per hour					
Lifting under 10 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
Lifting 10-25 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
Lifting 25-50 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
Lifting over 50 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
Carrying under 10 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
Carrying 10-25 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
Carrying 25-50 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
Carrying over 50 lbs.	☐	☐	☐	☐	☐	☐	☐	☐
Reaching above shoulder height	☐	☐	☐	☐	☐	☐	☐	☐
Client's ht. _________ highest reach _________	☐	☐	☐	☐	☐	☐	☐	☐
Reaching at shoulder height	☐	☐	☐	☐	☐	☐	☐	☐
Reaching below shoulder height	☐	☐	☐	☐	☐	☐	☐	☐
Use head/neck static position	☐	☐	☐	☐	☐	☐	☐	☐
Use head/neck frequently flexing	☐	☐	☐	☐	☐	☐	☐	☐
Use head/neck frequently rotating	☐	☐	☐	☐	☐	☐	☐	☐

14. Working environment:

☐ extreme cold ☐ extreme heat ☐ wet or humid ☐ noise
☐ vibration ☐ dusty ☐ fumes/odors ☐ temperature controlled
☐ slippery floors ☐ near moving equipment ☐ exposure to chemicals ☐ other: ______________________________

15. Job can be modified: temporarily ☐ yes ☐ no
permanently ☐ yes ☐ no

If, yes, specify:

16. Comments:

Completed by: Signature and Title

Completed with: Name of employer representative and title

I have reviewed this job analysis and agree with its content except for comments/corrections as noted above.

EMPLOYEE SIGNATURE

DATE

This employee (check one)

☐ can return to this job
☐ is projected to return to this job
☐ is permanently restricted from returning to this job

Comments:

SIGNATURE OF PHYSICIAN

DATE