JOB ANALYSIS

Name _____ Date _____
Employer Name _____ Job Title _____
Normal Shift Hours _____
Have you worked since the accident? ( ) Yes ( ) No Last Day worked _____
Job that you will be returning to_____

Check below those items which best describe your job performed at the time of injury.
Check only those that apply and the extent that each activity is performed.

	Number of Hours				
Activity	0	1-2	3-4	5-6	7+
Sitting					
Standing					
Walking					
Bending					
Crawling					
Climbing					
Reaching					
Crouching					
Kneeling					
Balancing					
Pushing or Pulling					

	Weight Handling Per Hour						Weight Handling Per Hour				
Lifting & Carrying	0	5-10	10-15	15-30	30+	**Lifting Overhead**	0	5-10	10-15	15-30	30+
10 lb or less						10 lb or less					
11-15 lbs						11-15 lbs					
51-75 lbs						51-75 lbs					
76-100 lbs						76-100 lbs					
Over 100 lbs						Over 100 lbs					

Any additional comments/concerns that we should be aware of?

_____
_____
_____
_____
_____