Department of Labor and Industries
Vocational Services

EMPLOYER'S JOB DESCRIPTION

Job Title ______________________ Claim # ______________________
Employer ______________________ Claimant ______________________
Phone # ______________________ Date ______________________

Description completed by: ______________________ Title ______________________

Essential task description:

Machinery, tools, equipment and personal protective equipment:

FOR EMPLOYER USE ONLY

PHYSICAL DEMANDS

N/A: Not Applicable
S: Seldom (1-10% of the time)
O: Occasional (10-30% of the time)
F: Frequent (30%-70% of the time)
C: Constant (Over 70% of the time)

		Frequency		Comments
Sitting				
Standing				
Walking				
Driving				
Lifting ( )lb.				
Carrying: ( )lb.				
Pushing/Pulling: ( ) lb.				
Climbing Stairs/Ladders				
Bending/twisting at waist				
Kneeling/squatting				
Crouching/Kneeling				
Crawling				
Reaching above shoulder				
Repetitive Arm/Hand Motion				
Handling/Grasping		% Pinch Grip ( ) % Power Grasp ( )		
Fine Finger Manipulation				
Talking				
Hearing				
Seeing				
Other: i.e., Noise/Toxic Chemicals/Fumes Dusts, etc.				

Employer: please include any Material Safety Data Sheets (MSDS)

Job Title ______________________ Claim # ______________________

Claimant ______________________

FOR PHYSICIAN'S USE ONLY

☐	The injured worker can perform the physical activities described in the job description and can return to work on _________.
☐	The injured worker can perform the physical activities described in the job description on a part-time basis for _______ hours per day. The worker an be expected to progress to regular duties in _______weeks/months.

The injured worker can perform the described job, but only with modifications/restrictions in the attached report and/or listed below. These modifications/restrictions are (check one):

☐ Temporary for _______________ Months ☐ Permanent Modifications

Date	Physician Signature

Approved ☐ Yes ☐ No