JOB DESCRIPTION

EMPLOYEE	CLAIM NUMBER	DATE
EMPLOYER	PREPARED BY	

JOB SPECIFICATIONS

JOB TITLE

☐ Full-time ☐ Part-time

WORKSETTING

TOOLS, EQUIPMENT, MACHINES USED

SPECIAL EQUIPMENT USED

PHYSICAL ACTIVITIES

To be completed by Employer or Employer Representative

UPPER EXTREMITIES	Yes	No
Reach Overhead	☐	☐
Reach Forward	☐	☐
Push/Pull	☐	☐
Handling/Fingering	☐	☐
TORSO & LOWER EXTREMITIES		
Kneeling	☐	☐
Crawling	☐	☐
Stooping	☐	☐
Twisting	☐	☐
Squatting	☐	☐

PHYSICAL ACTIVITIES	Yes	No
(On a daily basis; breaks every 2 hours)		
Standing	☐	☐
Sitting	☐	☐
Balancing	☐	☐
Climb Stairs	☐	☐
Climb/Other	☐	☐
Walk/Other	☐	☐

LIFTING & CARRYING

☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs.

LIFTING ONLY

☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs.

COMMENTS: _____

WAGES _____ WORK HOURS _____

Check below if either option applies: ☐ This job could be modified ☐ Another position could be available

EMPLOYER REPRESENTATIVE (PRINT)	EMPLOYER REPRESENTATIVE'S SIGNATURE	DATE
TITLE	COMPANY	

PHYSICIAN VERIFICATION

To be completed by Physican

I have reviewed the above job description and feel that this job is within the employee's physical performance abilities. The employee can:

1. Return to work on _____ (date). If "No," estimated date: _____
2. Upgrade physical limitations? _____ weeks.
3. Date MMI reached: _____ . If MMI not reached, estimated date: _____
4. Any permanent physical limitations? ☐ Yes ☐ No If "Yes," describe: _____

COMMENTS: _____

PHYSICIAN NAME (PRINT)	PHYSICIAN'S SIGNATURE	DATE

This document is advisory only and does not attempt to list all potential hazards or identify all possible remedial actions. You are responsible for the safety of your premises, operations, and products. FCCI Insurance Group and its affiliates and subsidiaries shall not be liable for any loss, injury, death, damage, or expense arising out of the use of this bulletin.