|  |  |  |
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| Department of Labor and IndustriesPhysician billing codes for Review of Job Analysis and Job Description:**1038M** – Limit one per day**1028M** – Each additional review | **state seal** | **Employer’s Job Description Form** |
| [ ]  Job of Injury[ ]  Permanent Modified[ ]  Light Duty/Transitional |

|  |  |  |  |
| --- | --- | --- | --- |
| Worker Name: |       | Claim Number: |       |
| Company Name: |       | Job Title: |       |
| Phone Number: |       | Fax Number: |       |
| Hours per day: |       | Days per Week: |       |

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| **Essential Job Duties:**      |
| **Machinery, Tools, Equipment, and Personal Protective Equipment:**      |

**Frequency Guidelines:**

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| --- | --- | --- |
| **N:** Never (not at all) | **S:** Seldom (1 – 10% of the time) | **O:** Occasional (11 – 33% of the time) |
| **F:** Frequent (34 – 66% of the time) | **C:** Constant (67 – 100% of the time) |  |

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| **Physical Demands:** | **Frequency:** | **Description of Task:** |
| Sitting |       |       |
| Standing |       |       |
| Walking |       |       |
| Heights/Ladders/Stairs |       |       |
| Twisting at the Waist |       |       |
| Bending/Stooping |       |       |
| Squatting/Kneeling |       |       |
| Crawling |       |       |
| Reaching Out |       |       |
| Talking/Hearing/Seeing | **L** | **R** | **B** |       |       |
| Working Above Shoulders | [ ]  | [ ]  | [ ]  |       |       |
| Handling/Grasping | [ ]  | [ ]  | [ ]  |       |       |
| Fine Finger Manipulation | [ ]  | [ ]  | [ ]  |       |       |
| Foot Controls | [ ]  | [ ]  | [ ]  |       |       |
| Driving | [ ]  | [ ]  | [ ]  |       |       |
| Repetitive Motion | [ ]  | [ ]  | [ ]  |       |       |
| Vibratory Tasks | H[ ]  | L[ ]  | [ ]  | [ ]  | [ ]  |       |       |
| Lifting (     ) lbs. | [ ]  | [ ]  | [ ]  |       |       |
| Carrying (     ) lbs. | [ ]  | [ ]  | [ ]  |       |       |
| Pushing/Pulling (     ) lbs. | [ ]  | [ ]  | [ ]  |       |       |
| Comments/Other:      |

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| --- | --- | --- |
|       |  |       |
| Employer Name (Please Print) |  | Title |

|  |  |  |
| --- | --- | --- |
|  |  |       |
| Employer Signature |  | Date |

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| --- |
| **For Healthcare Providers’ Use Only** |
| Approval [ ]  Yes [ ]  No [ ]  Approved with Modifications | Hours per Day:       | Days per Week:       | Effective Date:       |
| If no, please list the objective medical finding:      |
| If approved with modifications, describe the modifications needed:      |
|       |  |  |  |       |
| Healthcare Provider Printed Name |  | Healthcare Provider’s Signature |  | Date |