|  |  |  |
| --- | --- | --- |
| Department of Labor and Industries  Physician 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: |  |

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

**Frequency Guidelines:**

|  |  |  |  |
| --- | --- | --- | --- |
| **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) | |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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: | | | | | | | |

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

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | |