

Claimant name		Social Security number	
Claim number		Date of injury	
Job title	DOT number		Skill level (SVP)
Employer address		Contact person	
		Phone number	
		Fax number	
Job description			
Company stated qualifications			

<b>Job details</b>			
Days worked <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> TH <input type="checkbox"/> F <input type="checkbox"/> S		Hours per day	Hours per week
Salary	per hour / per day / per week / per month <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Lunch period

Physical demands: (N) = Never, (R) = Rarely, (O) = Occasionally [1-33%], (F) = Frequently [34-66%], (C) = Continuously [67-100%]

Climb	Push	Pull	Reach (where and how often)		
Balance	Stoop	Kneel			
Crawl	Handle	Squat			
Finger	Feel	Hear	Vision, near	Vision, far	Vision, depth perception
Taste/smell	Stand	Walk	Vision, accommodation	Vision, field	Vision, color discrimination
Sit	Lift under 5 lbs.	Lift 5-10 lbs.	Lift 11-15 lbs.	Lift 16-20 lbs.	Lift 21-25 lbs.
Foot controls	Lift 26-30 lbs.	Lift 31-35 lbs.	Lift 36-40 lbs.	Lift 41-45 lbs.	Lift 46-50 lbs.
Arm/hand controls	Lift 51-75 lbs.	Lift 75-100 lbs.	Lift over 100 lbs.		
Other					

**Working conditions**

- |                                 |                                    |  |                                  |                               |                                    |
|---------------------------------|------------------------------------|--|----------------------------------|-------------------------------|------------------------------------|
| <input type="checkbox"/> Inside | <input type="checkbox"/> Outside   | <input type="checkbox"/> Both inside and outside | <input type="checkbox"/> Cold    | <input type="checkbox"/> Heat | <input type="checkbox"/> Odor      |
| <input type="checkbox"/> Fumes  | <input type="checkbox"/> Vibration | <input type="checkbox"/> Wet/humidity            | <input type="checkbox"/> Heights | <input type="checkbox"/> Dust | <input type="checkbox"/> Chemicals |

**Noise**

- |                                     |                                |                                   |                               |                                    |
|-------------------------------------|--------------------------------|-----------------------------------|-------------------------------|------------------------------------|
| <input type="checkbox"/> Very quiet | <input type="checkbox"/> Quiet | <input type="checkbox"/> Moderate | <input type="checkbox"/> Loud | <input type="checkbox"/> Very loud |
|-------------------------------------|--------------------------------|-----------------------------------|-------------------------------|------------------------------------|

Hazards (please list)

Machines/tools/equipment/work aides

Essential functions

Work area (include any architectural barriers)

Other

Physician review  Approve  Disapprove

Physician signature

Required modifications

Comments

Date