

# Occupational On-Site Analysis

EMPLOYEE	SSN or WID	DATE OF INJURY	DATE OF ANALYSIS	CLAIM NUMBER
EMPLOYER	1. Title of job reviewed		Date of hire	Date began job
2. Training required to perform duties (number of)	Days	Weeks	Months	Years
3. Work hours	First break	Meal time	Last Break	Other
	to	to	to	
Overtime hrs per week	How often? <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____	Any work restrictions when hired? <input type="checkbox"/> No <input type="checkbox"/> Yes		
		If yes, please specify: _____		

4. General description of job:

5. Types of machines, tools, office equipment, and other special equipment used in job:

6. Vehicles or moving equipment driven as part of job:

7. In an 8 or 12 hour work day, employee can (check number of hours full capacity for each activity).

- a. Sit  1  2  3  4  5  6  7  8  9  10  11  12
- b. Stand  1  2  3  4  5  6  7  8  9  10  11  12
- c. Walk  1  2  3  4  5  6  7  8  9  10  11  12

Comments: (If appropriate, note frequency per hour or day)

8. Employee works (total must = 100%)	Inside percent	Outside percent
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9. While performing job, employee is required to: (check one)

- |                               | Not at All               | Occasionally             | Frequently               | Continuously             |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Twist                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Bend/Stoop (lumbar)        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cervical Bend              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Squat                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Crawl                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Climb Ladders              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Climb Stairs               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Reach Above Shoulder Level | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Crouch                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Kneel                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Balance                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Walk on Uneven Ground      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Work Above Ground          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Other: _____               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

10. The heaviest weight lifted while either sitting or standing in one place weighs \_\_\_\_\_ . The object's name is \_\_\_\_\_ and the estimated times lifted daily is \_\_\_\_\_ .

11. The heaviest weight carried while walking from place to place weighs \_\_\_\_\_ . The object's name is \_\_\_\_\_ and the estimated times carried daily is \_\_\_\_\_ .

12. The heaviest weight pushed/pulled lbs. of resistance \_\_\_\_\_ . The object's name is \_\_\_\_\_ and it is pushed/pulled a distance of \_\_\_\_\_ feet at a frequency of \_\_\_\_\_ # of times per hour \_\_\_\_\_ per day \_\_\_\_\_

13. Physical activity required

Total hours performed daily

Frequency per hour

	Never	Less than 1	1-2	3-4	5-6	7-8	9-10	11-12
Lifting under 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 10-25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting 25-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting over 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying under 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying 10-25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying 25-50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying over 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching above shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Client's ht. _____ highest reach _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching at shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching below shoulder height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use head/neck static position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use head/neck frequently flexing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use head/neck frequently rotating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Working environment:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> extreme cold    | <input type="checkbox"/> extreme heat          | <input type="checkbox"/> wet or humid          | <input type="checkbox"/> noise                  |
| <input type="checkbox"/> vibration       | <input type="checkbox"/> dusty                 | <input type="checkbox"/> fumes/odors           | <input type="checkbox"/> temperature controlled |
| <input type="checkbox"/> slippery floors | <input type="checkbox"/> near moving equipment | <input type="checkbox"/> exposure to chemicals | <input type="checkbox"/> other: _____           |

15. Job can be modified: temporarily  yes  no  permanently  yes  no If, yes, specify: \_\_\_\_\_

16. Comments: \_\_\_\_\_

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Completed by: Signature and Title	Completed with: Name of employer representative and title
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I have reviewed this job analysis and agree with its content except for comments/corrections as noted above.

EMPLOYEE SIGNATURE	DATE
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This employee (check one)

can return to this job

is projected to return to this job

is permanently restricted from returning to this job

Comments: \_\_\_\_\_

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SIGNATURE OF PHYSICIAN	DATE
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