

Physical Demands Analysis Form

Today's Date: ____/____/____

Injury Date: ____/____/____

Employee's Name: _____

Claim Number: _____

Case Manager: _____

Instructions to Supervisor: Please complete this physical demands analysis for your injured employee. It will help the medical provider and the case manager plan for a rapid and safe return to work. If you have any questions, please call the case manager at 1-800-985-7777.

NOTE: Enter a check mark to indicate frequency of each listed activity.

Activity	Number of Hours/Days	Occasional (1%-33%)	Frequent (36%-67%)	Constant (68%-100%)
		✓	✓	✓
Arm/Hand Usage: Lifting				
Bending/Squatting				
Climbing/Balancing				
Driving/Operate machinery				
Foot Control Operation				
Kneeling				
Standing				
Walking				
Repetitive Motion				
-hand/wrist				
-arm/shoulder				
Other:				
Activity	Wight (LB)	Occasional (1%-33%)	Frequent (36%-67%)	Constant (68%-100%)
		✓	✓	✓
Carrying				
Lifting				
Pulling/Pushing				
Other:				

Ability to accommodate return to work modified duty: Yes No

Is the Injured Worker exposed to any environmental conditions (temp, hazards, etc.) If so, what are the conditions?

Additional Comments: _____

Supervisor's Signature: _____ Date: ____/____/____