


JOB TITLE: _____

JOB DESCRIPTION:

Contact person if you might have any questions about this job description form:

| | | |
|--|--|--|
|  | | |
| | | |

Physical Demand Level

| | <input type="checkbox"/> Sedentary | <input type="checkbox"/> Light | <input type="checkbox"/> Medium | <input type="checkbox"/> Heavy | <input type="checkbox"/> Very |
|-------------------------------|------------------------------------|--------------------------------|---------------------------------|--------------------------------|-------------------------------|
| Occasional Lift: 1-33% | | | | | |
| Frequent Lift: 34-66% | | | | | |
| Constant Lift: 67-100% | | | | | |

Work Environment

| Description | % time | Description | % time | Description | % time |
|--|--------|---|--------|--|--------|
| <input type="checkbox"/> Extreme Hot | | <input type="checkbox"/> Dustiness | | <input type="checkbox"/> Below Ground | |
| <input type="checkbox"/> Extreme Cold | | <input type="checkbox"/> Dampness | | <input type="checkbox"/> Uneven Ground | |
| <input type="checkbox"/> Heated area | | <input type="checkbox"/> Vibrations | | <input type="checkbox"/> Fumes/Gases | |
| <input type="checkbox"/> Air Conditioned | | <input type="checkbox"/> Unprotected Height | | <input type="checkbox"/> Chemicals | |
| <input type="checkbox"/> Ventilated | | <input type="checkbox"/> Protective Equipment | | <input type="checkbox"/> Works with Others | |
| <input type="checkbox"/> Moving Vehicle | | <input type="checkbox"/> Excessive Noise | | <input type="checkbox"/> Works Alone | |

Equipment and Tools

| | Description | Frequency | Physical Demands |
|------------------|-------------|-----------|------------------|
| Equipment | | | |
| Tools | | | |

Physical Demands

| Activity | Hours Day | Continuous ↓ Intermittent | |
|----------|--------------|------------------------------|----------------------------|
| Stand | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Walk | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Sit | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Crouch | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Stoop | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Reach | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Balance | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Squat | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Kneel | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Crawl | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Push | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Pull | | <input type="checkbox"/> C | <input type="checkbox"/> I |

| Activity | Hours Day | Continuous ↓ Intermittent | |
|-------------------|--------------|------------------------------|----------------------------|
| Handle ↑ Shoulder | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Handle ↓ Shoulder | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Bend at Waist | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Twist at Waist | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Repetitive Hands | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Fingering | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Repetitive Feet | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Climb Stairs | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Climb Ladders | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Tilt Head | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Talk | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Drive | | <input type="checkbox"/> C | <input type="checkbox"/> I |

| | | | |
|-------------------------------|--|-----------------------|--|
| Movement with weights: | | Weight Amount: | |
|-------------------------------|--|-----------------------|--|

Sensory Demands

| Activity | Hours Day | Continuous ↓ Intermittent | |
|-------------|--------------|------------------------------|----------------------------|
| Feel | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Hear | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Taste/Smell | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Near Acuity | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Far Acuity | | <input type="checkbox"/> C | <input type="checkbox"/> I |

| Activity | Hours Day | Continuous ↓ Intermittent | |
|----------------------|--------------|------------------------------|----------------------------|
| Depth Perception | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Color Vision | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Field of Vision | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| Visual Accommodation | | <input type="checkbox"/> C | <input type="checkbox"/> I |
| | | <input type="checkbox"/> C | <input type="checkbox"/> I |

Work Hours and Scheduled Breaks

| Days | Hours | Breaks |
|-------------|--------------|---------------|
| | | |

Work Environment:

Job Modification Considerations:

Other