PHYSICAL DEMANDS FORM

Employee Name:	Position Title:
Agency:	Sub Agency:
Date Completed:	No. of Hours per Work Day:
Completed By Supervisor:	Phone #:
Treating Physician	Phone #:

I. Physical Demands of Position

Make the appropriate entry for each of the following items to describe the extent of the specific activity performed by this employee during the course of a typical work period.

4. Bending Over				
5. Climbing				
6. Reaching Overhead				
7. Kneeling				
8. Pushing or Pulling:				
a. With Legs				
b. With Arms				
c. With Body				
9. Lifting or Carrying:				
a. 10lbs or less				
b. 11 to 25lbs.				
c. 26 to 50lbs.				
d. 51 to 75lbs.				
e. 76 to 100lbs.				
f. Over 100lbs.				
10. Repetitive Use of Foot Control:				
a. Right Only				
b. Left Only				
c. Both				
11. Repetitive Use of Hands:				
a. Right Only				
b. Left Only				
c. Both				
12. Simple/Light Grasping:				
a. Right Only				
b. Left Only				
c. Both				
13. Firm/Strong Grasping:				
a. Right Only				
b. Left Only				
c. Both				

Physical Demands (continued)

14. Is employee required to drive a car? Yes__ No__
    If yes, please describe:_____
15. Is employee required to operate heavy equipment? Yes__ No__
    If yes, please describe:_____
16. Is employee exposed to dust, gas, or fumes? Yes__No__
    If yes, please explain:_____
17. Is employee exposed to marked changes in temperature or humidity? Yes__ No__
    If yes, please explain:_____

I. Work Schedule Requirements

Describe the employee's specific shifts (including rotating) and/or the hours worked, any travel requirements, and overtime

II. Physician Comments

Please complete the appropriate box below and provide comments as necessary.

ü I release_____to this position as described above.

ü I release_____to this position as described above with the following restrictions:_____

_____

_____

The medical rationale for this is:_____

_____

ü I am unable to release_____to this position as describe above.
The medical rationale for this is:_____

_____

Next appointment is scheduled for:_____

Physician's Signature:	**Date:**