Physical Demands Analysis Form

This form describes the physical demands of the employee's regular job. It is intended to be shared with the treating physician to help determine appropriate work restrictions and identify modified duty options. Please complete all sections and attach to the employee's medical referral.

Section 1: Employer Information

Company Name: _____ **Date:** _____

Address: _____ **Phone:** _____

Contact Person: _____ **Title:** _____

Email: _____ **Fax:** _____

Section 2: Employee and Position Information

Employee Name: _____ **Date of Injury:** _____

Job Title: _____ **Hire Date:** _____

Department: _____ **Claim #:** _____

Brief Job Description: _____

Work Schedule: _____ **Hours/Day:** _____ **Days/Week:** _____

Section 3: Overall Physical Demand Classification

Check the classification that best describes the overall physical demands of this position (per U.S. Department of Labor definitions):

- ☐ **Sedentary** — Lift up to 10 lbs occasionally. Primarily sitting with occasional walking/standing.
- ☐ **Light** — Lift up to 20 lbs occasionally, 10 lbs frequently. Walking/standing to a significant degree.
- ☐ **Medium** — Lift up to 50 lbs occasionally, 25 lbs frequently, 10 lbs constantly.
- ☐ **Heavy** — Lift up to 100 lbs occasionally, 50 lbs frequently, 20 lbs constantly.
- ☐ **Very Heavy** — Lift over 100 lbs occasionally, 50+ lbs frequently, 20+ lbs constantly.

Section 4: Physical Demands — Frequency Analysis

N = Never (0%) **O** = Occasionally (1–33%) **F** = Frequently (34–66%) **C** = Continuously (67–100%)

Physical Activity	N	O	F	C	Weight / Details
Sitting					
Standing					
Walking					
Climbing (stairs/ladders)					
Bending / Stooping					
Kneeling / Crouching					
Crawling					
Twisting / Turning					
Reaching (at/below shoulder)					

Physical Activity	N	O	F	C	Weight / Details
Reaching (above shoulder)					
Lifting (floor to waist)					___ lbs
Lifting (waist to shoulder)					___ lbs
Lifting (above shoulder)					___ lbs
Carrying					___ lbs
Pushing					___ lbs
Pulling					___ lbs
Grasping / Gripping					
Fine Finger Manipulation					
Keyboarding / Data Entry					
Driving (vehicle/equipment)					

Max Weight Lifted: _____ **Typical Weight Lifted:** _____ **Max Carry Distance:** _____

Section 5: Working Conditions and Environmental Exposures

Check all that apply and indicate frequency (**O** = Occasionally, **F** = Frequently, **C** = Continuously):

- ☐ Indoor work environment ____
- ☐ Outdoor work environment ____
- ☐ Extreme cold ____
- ☐ Extreme heat ____
- ☐ Wet / humid conditions ____
- ☐ Noise (loud machinery) ____
- ☐ Vibration exposure ____
- ☐ Dust / fumes / airborne particles ____
- ☐ Chemical exposure ____
- ☐ Heights / elevated work ____
- ☐ Confined spaces ____
- ☐ Moving mechanical parts ____
- ☐ Electrical hazards ____
- ☐ Uneven / slippery surfaces ____

Required PPE: _____

Section 6: Sensory and Cognitive Demands

- ☐ Near vision (close work)
- ☐ Far vision
- ☐ Depth perception
- ☐ Color discrimination
- ☐ Hearing (normal conversation)
- ☐ Hearing (alarms / equipment)
- ☐ Speech / verbal communication
- ☐ Reading / written comprehension
- ☐ Problem solving / decision making
- ☐ Concentration / attention to detail
- ☐ Working with others (teamwork)
- ☐ Working independently

Section 7: Essential Job Functions

List the essential functions of this position and their approximate percentage of work time:

#	Essential Function Description	% of Time	Can Be Modified?
1		___ %	Yes / No
2		___ %	Yes / No
3		___ %	Yes / No

#	Essential Function Description	% of Time	Can Be Modified?
4		___ %	Yes / No
5		___ %	Yes / No
6		___ %	Yes / No

Section 8: Modified / Transitional Duty Availability

The employer has the following modified duty options available. Please indicate whether the employee can perform these tasks given their current medical condition:

Modified Duty Task	Physical Demand	Physician Approval
Seated office/clerical work (filing, data entry, phone)	Sedentary	Approved / Not Approved
Light inspection / quality control (seated station)	Sedentary	Approved / Not Approved
Safety observation rounds (walking, no lifting)	Light	Approved / Not Approved
Parts/supply inventory (standing, lifting up to 20 lbs)	Light	Approved / Not Approved
Training and documentation review (seated, computer)	Sedentary	Approved / Not Approved
Shipping/receiving paperwork (seated, occasional standing)	Sedentary	Approved / Not Approved
		Approved / Not Approved
		Approved / Not Approved

NOTE TO PHYSICIAN: This employer participates in an active Return-to-Work program and has modified duty tasks available. Returning injured employees to meaningful work within their medical restrictions promotes faster recovery and better outcomes. Please provide specific work restrictions so we can identify appropriate modified duty assignments.

Section 9: Physician Response

To be completed by treating physician after reviewing the physical demands of the position.

Based on my evaluation, the employee:

- ☐ Can return to FULL DUTY performing all essential functions as described
- ☐ Can return to MODIFIED DUTY with the restrictions listed below
- ☐ CANNOT return to any work at this time

Work Restrictions (be as specific as possible): _____

Max Lifting: lbs _____ **Max Standing:** hrs/day _____ **Max Walking:** hrs/day _____

Expected duration of restrictions: _____

Next appointment date: _____ **Expected MMI date:** _____

EMPLOYER

Signature _____ Date _____

Printed Name / Title _____ Phone _____

PHYSICIAN

Signature _____ Date _____

Printed Name _____ Phone / Fax _____

This form is provided by First Underwriters Insurance Brokers as a resource for return-to-work programs. It does not constitute medical or legal advice.