



Dear Employer:

Attached is a Job Description Analysis form. This form is a tool to submit to the treating provider for approval for a specific light duty job offer for your injured worker. This form is used when a provider is apprehensive about submitting restrictions or when they are requesting to know the specifics of the job the injured worker will be involved with.

Please complete this form, being as specific as possible about the job you will be offering. Please do not complete this form based on their full duty job. The provider will be interested in how much physical exertion is required for the light duty job offer.

After completion of this form please fax it back to me, so that it can be forwarded to the provider for their consideration.

If you have questions please feel free to contact me at any time.

Thank you for your assistance,

Sheakley UniComp

513.326.8003 Phone  
888.743.2559 Phone  
888.626.2667 Fax

One Sheakley Way  
MCO  
Cincinnati, Ohio 45246

Sheakley.com  
mco@sheakley.com



**JOB DESCRIPTION ANALYSIS – ALTERNATE DUTY**

EMPLOYEE NAME \_\_\_\_\_ CLAIM # \_\_\_\_\_

JOB TITLE \_\_\_\_\_

WORK HOURS AND DAYS OF WEEK \_\_\_\_\_

ALTERNATE DUTY JOB DESCRIPTION \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DOES THIS JOB INCLUDE LIFTING? \_\_\_No  
\_\_\_Yes: \_\_\_ 0-10 lbs \_\_\_ 11-20 lbs \_\_\_ 21-50 lbs \_\_\_ 51-100 lbs \_\_\_ over 100 lbs

IF YES, IS THE LIFTING \_\_\_ Occasional or \_\_\_ Frequent

DOES THIS JOB REQUIRE BENDING, SQUATTING, KNEELING, CLIMBING, REACHING, TWISTING, ROTATING, CRAWLING, PUSHING OR PULLING? \_\_\_No \_\_\_Yes IF YES, DESCRIBE:

\_\_\_\_\_

DOES THIS JOB REQUIRE REPETITIVE MOVEMENT AND USE OF HANDS? \_\_\_No \_\_\_Yes

IF YES, DESCRIBE: \_\_\_\_\_

\_\_\_\_\_

IS THIS JOB \_\_\_ Primarily sitting \_\_\_ Primarily standing \_\_\_ Primarily walking  
\_\_\_ Other (describe) \_\_\_\_\_



**EMPLOYER SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



PHYSICIAN USE ONLY

\_\_\_ RELEASE TO RETURN TO FULL DUTIES ON \_\_\_\_\_ (DATE)

\_\_\_ RELEASE TO ALTERNATE/LIGHT DUTY ON \_\_\_\_\_ (DATE)

WORK RESTRICTIONS INCLUDE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_



*Please fax to Sheakley UniComp at 1-888-626-2667*