TEMPORARY LIGHT DUTY JOB ANALYSIS

Employee:	Date Of Injury:
Employer: University of Hawaii	FICOH Claim Number:
Address:	
Contact Person (Form Prepared by):	Phone:
Duration and number of hours per week:	
Duties and Responsibilities:	

PHYSICAL REQUIREMENTS:

☐ Standing _____ Hrs. at one time _____ Total Hrs. Per Day

☐ Sitting _____ Hrs. at one time _____ Total Hrs. Per Day

☐ Walking _____ Hrs. at one time _____ Total Hrs. Per Day

	80+	70	60	50	40	30	20	10	5	<5
Lifting MAXIMUM lbs.										
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0-33%)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Carrying MAXIMUM lbs.										
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0-33%)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Push/Pull MAXIMUM lbs.										
Frequently (34-66%)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0-33%)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Movements: ☐ Bend ☐ Reach ☐ Squat ☐ Kneel - Duration_____ hrs.

☐ Climb ☐ Push/Pull _____ Lbs.

Operate Machinery: ☐ *NO* ☐ *YES* **TYPE:**

OTHER PHYSICAL REQUIREMENTS/COMMENTS:

_____

PHYSICIAN APPROVAL - I REVIEWED THE LIGHT DUTY JOB ANALYSIS AND BELIEVE THE EMPLOYEE:

☐ Is Able to Perform These Duties
☐ Is Able to Perform These Duties With The Following Accommodation:
☐ Is Unable to Perform These Duties

PHYSICIAN SIGNATURE:_____ DATE:_____

EMPLOYEE ACKNOWLEDGEMENT:

(Signature)_____ DATE:_____