MANITOBA BLUE CROSS®

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JOB ANALYSIS
Disability Claim

To be completed by the employee's direct supervisor based on the regular duties performed immediately before injury or illness.
Submit directly to Manitoba Blue Cross, Case Management Services. See contact information above.

Section 1 Employer Identification

Employer/Company Name	Plan Name (if different from Employer)	Policy ID Number

Section 2 Employee (Member) Identification

Employee (Member) Name (Last, First, Middle Initial)	Job Title	Start date of the current position (dd/mm/yyyy)

Regular Work Schedule Total hours worked, each week Number of days/shifts worked each week

Usual scheduled work days, each week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Usual scheduled work hours, each shift: _____ ☐ a.m. ☐ p.m. to _____ ☐ a.m. ☐ p.m

*If this position requires a varied schedule or rotational shifts, please provide details.

DETAILS:

Section 3 Job Description (Regular Duties)

Provide details of the essential tasks/activities performed by this employee on a regular and/or daily basis. (list most important first)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Section 4 Job Requirements (Physical Tasks)

Provide details of the physical tasks performed by this employee.

TABLE 1 For each activity please indicate:

ACTIVITY	N/A	TASK IS ESSENTIAL TO JOB	TASK COULD BE MODIFIED	FREQUENCY DAILY (D) WEEKLY (W) MONTHLY (M)	% OF TIME OF TASK 0 TO 33%	34 TO 66%	67 TO 100%
Sitting	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Standing	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Walking	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Stairs and/or Steps	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Reaching - overhead	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Reaching - must lean forward or to the side	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Crawling and/or Climbing	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Bending and/or Crouching	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Kneeling and/or Squatting	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Fine Manipulation and/or Gripping Objects	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Repetitive Body Motions	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐

Is the employee able to change body positioning as comfort requires: ☐ Yes ☐ No Comments: _____

TABLE 2 For each activity please indicate: FREQUENCY = Daily (D) Weekly (W) Monthly (M)

ACTIVITY	N/A	0-10 LBS FREQUENCY, DURATION	11-20 LBS FREQUENCY, DURATION	21-50 LBS FREQUENCY, DURATION	>50 LBS FREQUENCY, DURATION
Lifting	☐	☐ D ☐ W ☐ M, ____hrs/shift	☐ D ☐ W ☐ M, ____hrs/shift	☐ D ☐ W ☐ M, ____hrs/shift	☐ D ☐ W ☐ M, ____hrs/shift
Carrying	☐	☐ D ☐ W ☐ M, ____hrs/shift	☐ D ☐ W ☐ M, ____hrs/shift	☐ D ☐ W ☐ M, ____hrs/shift	☐ D ☐ W ☐ M, ____hrs/shift
Pushing/Pulling	☐	☐ D ☐ W ☐ M, ____hrs/shift	☐ D ☐ W ☐ M, ____hrs/shift	☐ D ☐ W ☐ M, ____hrs/shift	☐ D ☐ W ☐ M, ____hrs/shift

To complete job tasks; lift, carry, push, or pull assistive devices are: ☐ Required ☐ Available ☐ Not Required

Comments: _____

Section 5 Job Requirements (Cognitive Tasks)

Provide details of the cognitive tasks performed by this employee.

ACTIVITY	N/A	TASK IS ESSENTIAL TO JOB	TASK COULD BE MODIFIED	FREQUENCY DAILY (D) WEEKLY (W) MONTHLY (M)	% OF TIME OF TASK 0 TO 33%	34 TO 66%	67 TO 100%
Understand, remember, and carry out detailed instructions	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Maintain attention and concentration for extended periods	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Perform activities within a schedule	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Work involves pressure to meet deadlines	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Juggle tasks and prioritize work	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Sustain an ordinary routine without supervision	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Make simple decisions or solve straightforward problems	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Solve complex problems	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Work alone or independently	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Work in a team or with others	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Interact with the general public or customers	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Respond to frequent changes in the environment or tasks	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐
Travel in unfamiliar places or use public transportation	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐ D ☐ W ☐ M	☐	☐	☐

Section 6 Job Requirements (Work Environment)

Identify any specific conditions and/or environments this employee may be exposed to during work.

Location? (i.e. unregulated inside climate, outside, in vehicle, operating heavy equipment, etc.)

Hazards? (i.e. chemicals, biological agents, equipment, machinery, tools, moving objects, heights, etc.)

Discomforts? (i.e. noise, vibration, odours, non-toxic dust, exposure to marked temperature or humidity, etc.)

Section 7 Other Information (Accommodation)

Before the employee stopped working, did the injury or illness cause him/her to change the following:

		DATE OF CHANGE (dd/mm/yyyy)	EXPLANATION OF CHANGE
Job Duties	☐ Yes ☐ No ☐ N/A		
Job Performance	☐ Yes ☐ No ☐ N/A		
Use of Equipment	☐ Yes ☐ No ☐ N/A		
Hours of Work	☐ Yes ☐ No ☐ N/A		
Attendance	☐ Yes ☐ No ☐ N/A		

Has your employee had more than one job with your company? ☐ Yes ☐ No If yes, list all job titles and time spent at each job:

Based on your employee's skills, please comment on any opportunity for alternate job placement within your company:

Section 8 Declaration and Signature

I hereby declare that the information provided on this form is true and complete to the best of my knowledge and belief.

Name (please print)	Position/Title
Phone (include area code)	Fax (include area code)
Signature	Date (dd/mm/yyyy)