summit BACK2WORK®

Job Analysis/Physical Demands

You can download this form by logging in to our Online Business Center at *www.summitholdings.com*.
To be completed by the employer, then sent to the treating physician.

Employee name _____ Date _____

Job title _____ Claim number _____

❑ Full time ❑ Part time Hours/day _____ Hours/week _____

Work setting information *(Please check all that apply.)* ❑ Inside ❑ Outside ❑ Carpet ❑ Concrete ❑ Uneven surface ❑ Air conditioned

Physical demands of job

❑ Regular Duty ❑ Transitional Duty

Indicate the number of hours the employee will be expected to perform the following. Please indicate whether the activity can be performed continuously or intermittently.

Sit	0 1 2 3 4 5 6 7 8	❑ Continuously	❑ Intermittently
Stand	0 1 2 3 4 5 6 7 8	❑ Continuously	❑ Intermittently
Walk	0 1 2 3 4 5 6 7 8	❑ Continuously	❑ Intermittently

Indicate whether or not the employee will be required to:

Climb	❑ Yes	❑ No	❑ Limited. Please specify:	_____
Twist/Bend/Stoop	❑ Yes	❑ No	❑ Limited. Please specify:	_____
Reach above shoulder level	❑ Yes	❑ No	❑ Limited. Please specify:	_____
Operate a motor vehicle	❑ Yes	❑ No	❑ Limited. Please specify:	_____
Push/Pull	❑ Yes	❑ No	❑ Limited. Please specify:	_____
Fine-finger movements	❑ Yes	❑ No	❑ Limited. Please specify:	_____

Indicate the physical demands and frequency for lifting and carrying.

0 – 10 lbs.	❑ Never (0%)	❑ Occasionally (1% – 35%)	❑ Frequently (36% – 66%)	❑ Continuously (67% – 100%)
11 – 20 lbs.	❑ Never (0%)	❑ Occasionally (1% – 35%)	❑ Frequently (36% – 66%)	❑ Continuously (67% – 100%)
21 – 40 lbs.	❑ Never (0%)	❑ Occasionally (1% – 35%)	❑ Frequently (36% – 66%)	❑ Continuously (67% – 100%)
41 – 60 lbs.	❑ Never (0%)	❑ Occasionally (1% – 35%)	❑ Frequently (36% – 66%)	❑ Continuously (67% – 100%)
More than 60 lbs.	❑ Never (0%)	❑ Occasionally (1% – 35%)	❑ Frequently (36% – 66%)	❑ Continuously (67% – 100%)

_____ _____

Signature of employer Date

For the physician

Note to Florida physicians
After you review the information above, please complete the Florida Workers' Compensation Medical Treatment/Status Reporting form (DFS-FS-DWC-25), Section IV, "Functional Limitations and Restrictions." That portion of the form should be used to report work status at each office visit. You may be asked to complete other forms if additional information is needed, but you do not need to complete the information below.

In your opinion, what limits the patient from performing the above-described tasks? _____

Patient is able to return to full-time work effective: _____

Patient is able to return to work effective _____, with the following work restrictions (please indicate duration): _____

_____

I have reviewed the above description of the employment to be offered, and I feel that this job ❑ is ❑ is not within the patient's physical abilities. ***(Please fax this form to the Summit office in your region, listed below.)***

_____ _____

Physician's signature (no stamp or other facsimile) Date

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