



Job Analysis

500-5000 Yonge Street
Toronto, ON M2N 7J8
Telephone: 1-800-846-5970
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Insured's name: _____ Policy number(s): _____

Date began present position: DD/MM/YYYY Last Day Worked: DD/MM/YYYY WCB/WSIB Claim #: _____

Note: Job Analysis to be completed by the claimant's immediate Supervisor, unless self-employed. Please enclose a Physical Demands of Occupation form if you have one on file.

Occupation and General Job Description (Prior to disability)

Work Schedule: (i.e.: Full-time Day or Night shift, Part-time Day or Night shift, Work Hours)

Environment: (i.e.: Temperature, Light, Noise, Vapours/Fumes, Physical Hazards, etc:)

Physical Demands of Pre-disability Occupation

Please choice the appropriate number below for each Job requirement

- Legend**
- 0 – Never performed
 - 1 – Sometimes performed
 - 2 – Performed occasionally, less than 1 hour per day
 - 3 – Frequent and/or repetitious for 1-3 hours daily
 - 4 – Maximum job requirement for over 3 hours per day

Sitting Chair		0○	1○	2○	3○	4○
Vehicle Seat		0○	1○	2○	3○	4○
Standing		0○	1○	2○	3○	4○
Walking	Level Surface	0○	1○	2○	3○	4○
	Uneven Surface	0○	1○	2○	3○	4○
	Stairs	0○	1○	2○	3○	4○
Climbing	Ladders	0○	1○	2○	3○	4○
	Scaffolding	0○	1○	2○	3○	4○
	Other	0○	1○	2○	3○	4○
Bending	Stooping	0○	1○	2○	3○	4○
	Crouching	0○	1○	2○	3○	4○
	Kneeling	0○	1○	2○	3○	4○
Lifting	From ground level	0○	1○	2○	3○	4○
	From waist level	0○	1○	2○	3○	4○
	Above waist level	0○	1○	2○	3○	4○
Lifting Requirements	Up to 10 lbs (4.54 kgs)	0○	1○	2○	3○	4○
	10 to 25 lbs (4.54 to 11.3 kgs)	0○	1○	2○	3○	4○
	25 to 50 lbs (11.3 to 22.7 kgs)	0○	1○	2○	3○	4○
	over 50 lbs (22.7 kgs)	0○	1○	2○	3○	4○
Mobility	Carrying	0○	1○	2○	3○	4○
	Pushing	0○	1○	2○	3○	4○
	Pulling	0○	1○	2○	3○	4○
	Crawling	0○	1○	2○	3○	4○

Carrying, Pushing and Pulling Requirements

Up to 10 lbs (4.54 kgs)	0○	1○	2○	3○	4○
10 to 25 lbs (4.54 to 11.3 kgs)	0○	1○	2○	3○	4○
25 to 50 lbs (11.3 to 22.7 kgs)	0○	1○	2○	3○	4○
over 50 lbs (22.7 kgs)	0○	1○	2○	3○	4○

Types of machines, equipment, tools and work aids required to perform occupation:

Vehicles or equipment driven at work:

Repetitive motions required: (at wrist, shoulder, hip, knee, other)

Job Modifications: (Can job duties and work hours be modified to accommodate claimants physical restrictions?)

Job site Modifications: (What physical changes can be implemented to accommodate a return to work?)

Worker Modifications: (What physical aids can be provided to accommodate a return to work?)

Declaration and Signature:

I certify that the above statements are true and complete to the best of my knowledge and belief.

Date: DD/MM/YYYY

Signature of Authorized Official

Name of Authorized Official

Telephone Number