

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

JOB ANALYSIS

Instructions: File this form as an attachment to a WC-240

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Date of Injury
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EMPLOYER	Name	Contact Person
	Job Title	Position
Phone Number	Prepared by:	Date:

SCHEDULE		
Shift(s):	Days:	
Hours / Week:	Overtime:	Rate of Pay:
JOB DESCRIPTION (What is the purpose and objective of this job?):		

WORK PACE		
Self-Paced? <input type="checkbox"/> Yes <input type="checkbox"/> No	Incentive Based? <input type="checkbox"/> Yes <input type="checkbox"/> No	Machine Paced? <input type="checkbox"/> Yes <input type="checkbox"/> No
Production Standards (Define Requirements):		

WEIGHT	FREQUENCY				OBJECTS	Lowest Point Lift/Lower	Highest Point Lift/Lower
	Never	Occasional (up to 1/3 of the time)	Frequent (1/3 to 2/3 of the time)	Constant (over 2/3 of the time)		Height	Height
LIFTING							
Negligible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
20 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
25 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
50 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
100 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Over 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
CARRYING						Max. Distance Carried	
Negligible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
20 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
25 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
50 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
100 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Over 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
PUSH/PULL MAX FORCE						Max. Distance Moved	
Negligible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
10 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
20 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
25 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
50 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
100 lbs. Max.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Over 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbwcc.ga.gov>
 WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

POSTURES / MOVEMENTS	MAX. CONSEC. MIN/HOURS	TOTAL DAILY HOURS	POSITION CHANGE OPTIONAL?	FURTHER DESCRIPTION
Sitting				
Standing (in place)				
Walking				
Use Arm/Leg Controls				
	Never	Occasional (up to 1/3 of the time)	Frequent (1/3 to 2/3 of the time)	Constant (over 2/3 of the time)
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn/Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching (out)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching (up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist Turning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pinching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LIST EQUIPMENT, MACHINES, TOOLS, VEHICLES USED

SPECIAL CONSIDERATIONS (ENVIRONMENTAL CONDITIONS, VISION, HEARING, HEIGHT)

Employer's Signature	(Title)	Date
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TO BE FILLED OUT BY THE AUTHORIZED TREATING PHYSICIAN			
<p>1. Employee can perform this job while taking medications as prescribed <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> I do release the employee to the job described</p> <p>3. <input type="checkbox"/> I do not release the employee to the job described</p> <p>4. <input type="checkbox"/> I only release the employee to the job described with the following restrictions/limitations/modifications:</p>			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%;">Physician's Name</td> <td style="width: 30%;">Physician's Signature</td> <td style="width: 25%;">Date</td> </tr> </table>	Physician's Name	Physician's Signature	Date
Physician's Name	Physician's Signature	Date	

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