GEORGIA STATE BOARD OF WORKERS' COMPENSATION
JOB ANALYSIS

Employee Name:		SSN:
Company:		Contact Person:
Job Title:		Position:
Prepared By:	Date:	Telephone Number:

SCHEDULE	WORK PACE		
Shift(s):	Self-Paced:	Yes ❑	No ❑
Days:	Incentive Based:	Yes ❑	No ❑
Hours/Week:	Machine Paced:	Yes ❑	No ❑
Overtime:	Production Standards (Define Requirements):		
Rate of Pay:			

JOB DESCRIPTION (What is the purpose and objective of this job?):

WEIGHT	FREQUENCY				OBJECTS	Lowest Point Lift/Lower	Highest Point Lift/Lower
LIFTING	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
Negligible							
10 lbs. Max.							
20 lbs. Max.							
25 lbs. Max.							
50 lbs. Max.							
100 lbs. Max.							
Over 100 lbs.							

CARRYING						Max. Distance Carried
Negligible						
10 lbs. Max.						
20 lbs. Max.						
25 lbs. Max.						
50 lbs. Max.						
100 lbs. Max.						
Over 100 lbs.						

PUSH/PULL MAX FORCE						Max. Distance Moved
Negligible						
10 lbs. Max.						
20 lbs. Max.						
25 lbs. Max.						
50 lbs. Max.						
100 lbs. Max.						
Over 100 lbs.						

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).

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					
Turn/Twisting					
Kneeling					
Squatting					
Crawling					
Climbing					
Reaching (out)					
Reaching (up)					
Wrist Turning					
Grasping					
Pinching					
Finger Manipulation					

EQUIPMENT, MACHINES, TOOLS, VEHICLES USED

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

Employer's Signature (Title) Date

TO BE FILLED OUT BY AUTHORIZED TREATING PHYSICIAN

1. Employee can perform this job while taking medications as prescribed Yes ❑ No ❑
2. _____ I do release the employee to the job described
3. _____ I do not release the employee to the job described
4. _____ I only release the employee to the job described with the following restrictions/limitations/modifications

Physician's Signature Date

Physician's Name

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