



Physical Demands Analysis

Job Title:	Hours per shift:
-------------------	-------------------------

List the tasks associated with the job from most essential to least essential:

Equipment used:	Hand tools used:

Consider the following actions and determine the frequency in which they are conducted for this job.

Frequency of task	>20%	25-45%	50-75%	<80%
MOBILITY				
Walking				
Standing				
Sitting				
Crawling				
Driving				
POSTURE				
Bending forward				
Bending backward				
Twisting				
Above Shoulder reach				
Chest to Shoulder reach				
Below Chest reach				
Behind Body reach				
Elbow flex/extend				
Wrist flex/extend				
Wrist rotation				
Neck forward bend				
Neck backward bend				
Neck tilt/turn				
Crouching/Squatting				
Kneeling				
Jumping				
Climbing				
Foot flex/extend				

PHYSICAL DEMANDS				
------------------	--	--	--	--

Lifting				
Carrying				
Pushing/Pulling				
Pinching				

OTHER CONDITIONS or DEMANDS				
-----------------------------	--	--	--	--

Environmental Conditions	<input type="checkbox"/> Hot	<input type="checkbox"/> Sharp	<input type="checkbox"/> Electromagnetic Field
	<input type="checkbox"/> Noise	<input type="checkbox"/> Dry	<input type="checkbox"/> Humid
	<input type="checkbox"/> Slippery	<input type="checkbox"/> Traffic	<input type="checkbox"/> Work at Height
	<input type="checkbox"/> Cold	<input type="checkbox"/> Fumes/Vapour	<input type="checkbox"/> Vibration
	<input type="checkbox"/> Congested	<input type="checkbox"/> Outdoor	<input type="checkbox"/> Other:
	<input type="checkbox"/> Glare	<input type="checkbox"/> Lighting	
Psychological demands	<input type="checkbox"/> Under pressure	<input type="checkbox"/> Multitasking	<input type="checkbox"/> Repetitive tasks
	<input type="checkbox"/> Direct supervision	<input type="checkbox"/> Confrontations	<input type="checkbox"/> Irregular work hours
	<input type="checkbox"/> Working alone	<input type="checkbox"/> Group work	<input type="checkbox"/> Attention to detail
	<input type="checkbox"/> Fast paced work	<input type="checkbox"/> Complex tasks	<input type="checkbox"/> Overtime
	<input type="checkbox"/> Mentor	<input type="checkbox"/> Incentives/Commission	<input type="checkbox"/> Other:
	<input type="checkbox"/> Illiterate	<input type="checkbox"/> Travel	
Sensory Demands	<input type="checkbox"/> Hearing	<input type="checkbox"/> Far Vision	<input type="checkbox"/> Smell
	<input type="checkbox"/> Taste	<input type="checkbox"/> Spatial perception	<input type="checkbox"/> Other:
	<input type="checkbox"/> Speech	<input type="checkbox"/> Colour vision	
	<input type="checkbox"/> Near Vision	<input type="checkbox"/> Tactile	

Name of worker being examined:	Date:
Signature:	

Name of Supervisor:	Date:
Signature:	

Name of assessing Doctor:	Date:
Signature	