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

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? ☐ Yes ☐ No	Incentive Based? ☐ Yes ☐ No	Machine Paced? ☐ Yes ☐ No
Production Standards (Define Requirements):		

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.	☐	☐	☐	☐			

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

LIST EQUIPMENT, MACHINES, TOOLS, VEHICLES USED

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

Employer's Signature	(Title)	Date

TO BE FILLED OUT BY THE 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 Name	Physician's Signature	Date

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