



WORK RESTRICTIONS FORM

Please fill in the sections that are applicable

Employee Name _____ Location _____ Employee Number _____

Employee has restrictions Yes No Estimated duration of the restrictions? _____

Posture/Movement

Please indicate in hours/minutes

Example Sit for 2 Hrs at a time for a total of 8 Hr with a 15 mi break of sitting ____ standing x walking x

Sit for _____ at a time for a total of _____ with a _____ break of sitting ____ standing ____ walking ____

Stand for _____ at a time for a total of _____ with a _____ break of sitting ____ standing ____ walking ____

Walk for _____ at a time for a total of _____ with a _____ break of sitting ____ standing ____ walking ____

STRENGTH (please use letters to indicate frequency)

N = Never

O = Occasional (under 2-1/2 hours)

F = Frequent (2-1/2 to 5 hours)

C = Continuously (over 5 hrs)

Weight in Lbs. (to 10) (11-20) (21-50) (51-75)

Lift/Carry Below Waist _____

Lift/Carry Waist/Chest _____

Lift/Carry Above Shoulder _____

Push/Pull _____

Hand/Foot Movement

N **O** **F** **C**

Simple grasp (< 8# of force) _____

Power grasp (> 8# of force) _____

Finger/fine manipulation _____

Foot controls _____

Repetitive hand movements _____

Kneel _____

Bend _____

Squat _____

Climb _____

Reach: Above Shoulders ____ At or Below Shoulders ____

MENTAL AND PSYCHOLOGICAL DEMANDS

Basic work

Yes No

Follow verbal instructions

Follow written instructions

Maintain the established workflow

Maintain the established work pace

Adhere to established work and safety procedures

Attention to Task/Details

Yes No

Perform simple or repetitive tasks

Perform complex or varied tasks

Organize tasks and set priorities

Perform and or direct multiple tasks simultaneously

Interaction with Others

Work cooperatively with coworkers

Interact and deal with customers or the public

Direct or supervise others

Maintain composure under all circumstances

Respond appropriately to direction and evaluation

Work autonomously, or with minimal supervision

Decision Making

Give training or instruction

Use basic problem-solving techniques

Make independent judgments and decisions based on data/circumstances

ENVIRONMENTAL CONDITIONS

Exposure to weather

N O F C

N O F C

Between

_____ and _____ degrees _____

_____ and _____ degrees _____

Wet or humid

Exposure to sun

Vibration

Proximity to moving
mechanical hazards

Exposure to loud noise

Sensitivity to chemicals? Yes No Explanation _____

Meets food-handling standard pursuant to FDA Food Code and/or similar state laws? Yes No

Explanation _____

Other environmental conditions? _____

Please suggest personal protective equipment that would allow employee to work in environment: _____

SENSORY

Vision _____

Auditory _____

Noise _____

Other Senses _____

Max hours employee can work per day _____

Max days per week employee can work _____

ADDITIONAL NOTES

Restrictions and clarifications that are medically necessary

Health Care Provider Name: _____

Type of Practice: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____