

JOB DESCRIPTION FORM

PLEASE NOTE:

- To be completed by the employee's direct supervisor based on the regular duties performed immediately before injury or illness.
- · Submit directly to Saskatchewan Blue Cross, Case Management Services. See contact information above.

EMPLOYER IDENTIFICATION (p	lease print)	
Employer/Company Name	Plan Name (if different from Employer)	Policy Number
Employer/Company Name	Plan Name (ii dinerent from Employer)	Policy Number
EMPLOYEE (MEMBER) IDENTIF	ICATION	
Employer/Company Name	Plan Name (if different from Employer)	Policy Number
Danielan Wards Cabadular Tatal bassis	No.	
Regular Work Schedule: Total hour	s worked, each week: Nun	nber of days/shifts worked, each week:
Usual scheduled work days, each week:	Monday Tuesday Wednesday	Thursday Friday Saturday Sunday
	A.M.	A.M.
Usual scheduled work hours, each shift:	to	
	P.M.	P.M.
JOB DESCRIPTION (REGULAR I	DUTIES	
	rities performed by this employee on a regular and	/or daily hasis (list most important first)
Tovide details of the essential tasks, activ	rities performed by this employee on a regular una	or daily basis (list most important mist).
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6.		





JOB REQUIREMENTS (PHYSICAL TASKS)

Provide details of the physical tasks performed by this employee.

For each activity please indicate:

ACTIVITY		N/A	TASK IS ESSENTIAL TO JOB	TASK COULD BE MODIFIED	Daily (D)	FREQUENCY Weekly (W)		% OF 0-33%	TIME ON 34-66%	TASK 67-100%
Sitting			Yes No	Yes No	D	W	М			
Standing			Yes No	Yes No	D	W	М			
Walking			Yes No	Yes No	D	_ w	М			
Stairs and/or Steps	S		Yes No	Yes No	D	_ w	М			
Reaching -overhea	ad		Yes No	Yes No	D	_ w	М			
Reaching - must le forward or to the s			Yes No	Yes No	D	W	М			
Crawling and/or Climbing			Yes No	Yes No	D	_ w	М			
Bending and/or Crouching			Yes No	Yes No	D	_ w	М			
Kneeling and/or Squatting			Yes No	Yes No	D	_ w	М			
Fine Manipulation or Gripping Object			Yes No	Yes No	D	_ w	М			
Repetitive Body M	lotions		Yes No	Yes No	D	_ w	М			
Is the employee able to change body positioning as comfort requires: Yes No Comments:										
ACTIVITY	N/A	FREG	0-10 LBS QUENCY, DURATION	11-20 LBS FREQUENCY, DURA	ATION	21-50 L FREQUENCY, [FREQU	>50 LBS JENCY, DU	RATION
Lifting			W M hrs/shift	D W M	hrs/shift	D W M	hrs/shift	DDV	V 🗌 M 🗕	hrs/shift
Carrying			W M hrs/shift	□ D □ W □ M	hrs/shift	D D W M	hrs/shift	□ D □ V	V 🗌 м _	hrs/shift
Pushing/Pulling			W M hrs/shift	D W M	hrs/shift	D W M	hrs/shift	□ D □ V	v 🗌 M _	hrs/shift
To complete job tasks, lift, carry, push, or pull assistive devices are: Required Available Not Required										
Comments:										



JOB REQUIREMENTS (COGNITIVE TASKS)

Provide details of the cognitive tasks performed by this employee.

For each activity please indicate:

ACTIVITY	N/A	TASK IS ESSENTIAL TO JOB	TASK COULD BE MODIFIED	Daily (D)	FREQUENCY Weekly (W)	Monthly (M)	% OF 0-33%	TIME ON 34-66%	TASK 67-100%
Understand, remember, and carry out detailed instructions		Yes No	Yes No	D		М			
Maintain attention and concentration for extended periods		Yes No	Yes No	D	□ w	М			
Perform activities within a schedule		Yes No	Yes No	D	□ w	М			
Work involves pressure to meet deadlines		Yes No	Yes No	D	□ w	М			
Juggle tasks and prioritize work		Yes No	Yes No	D	□ w	М			
Sustain an ordinary routine without supervision		Yes No	Yes No	D	□ w	М			
Make simple decisions or solve straightforward problems		Yes No	Yes No	D	_ w	М			
Solve complex problems		Yes No	Yes No	D	_ w	М			
Work alone or independently		Yes No	Yes No	D	□ w	М			
Work in a team or with others		Yes No	Yes No	D	□ w	М			
Interact with the general public or customers		Yes No	Yes No	D	□ w	М			
Respond to frequent changes in the environment or tasks		Yes No	Yes No	D	□ w	М			
Travel in unfamiliar places or use public transportation		Yes No	Yes No	D	_ w	М			
JOB REQUIREMENTS (WORK ENVIRONMENT)									
Identify any specific conditions and/or environments this employee may be exposed to during work.									
Location? (i.e. unregulated inside climate, outside, in vehicle, operating heavy equipment, etc.)									
Hazards? (i.e. chemicals, biological agents, equipment, machinery, tools, moving objects, heights, etc.)									
Discomforts? (i.e. noise, vibration, odors, non-toxic dust, exposure to marked temperature or humidity, etc.)									

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OTHER INFORMATION (ACCOMMODATION)							
Before the employee	stopped working, did the injury or i	llness cause him/her to change	the following:				
		Date of Change (YYYY/MM/DD)	Explanation of Change				
Job Duties	Yes No N/A						
Job Performance	Yes No N/A						
Use of Equipment	Yes No N/A						
Hours of Work	Yes No N/A						
Attendance	Yes No N/A						
Based on your employee's skills, please comment on any opportunity for alternate job placement within your company:							
DECLARATION AND SIGNATURE I hereby declare that the information provided on this form is true and complete to the best of my knowledge.							
Direct Supervisor Name (please print)							
Position/Title		Phone (include area code)				
Fax (include area co	ode)	Email A	ddress				
Signature		Date (Y	YYY/MM/DD)				