



Completing the Physical Job Description Form

Instructions Page

The Physical Job Description Form (PJD) is a form used to gather and document key information about the physical demands of the job. This form will assist with rehabilitation planning, medical decision making, and return to work.

***This form can be printed and filled out manually or completed on-line and emailed back to Beacon.**

Who should complete this form?

Ideally, the worker's immediate supervisor should complete the PJD. Input should be gathered by observing the workers who perform the actual job tasks and are familiar with the work processes involved. Involve the injured worker in the process whenever possible.

Do I need to fill out the entire form?

You must fill out pages 1 – 4. Consider all aspects of the worker's job demands. Some portions of the PJD form may not be applicable for the job you are describing and if so please indicate using "n/a". Please note Appendix A is only for workers who have direct contact and handling of patients or clients, i.e., health care, group home, and child care workers.

Do I need to send the company job description along with this form?

Yes, please attach a copy of your company's current, most up to date, written job description.

Modified Duty Options

Please fill out the Modified Duty Options page of the form. Modified or transitional duty allows the injured worker to get back to work by performing lighter, less demanding tasks and/or working reduced hours. It also promotes a faster recovery and reduces claim costs. Please note, if your company is already a Stay-at-Work/Return-to-Work (SAW/RTW) participant, these task banks should already be available. For more information regarding the SAW/RTW program, please go to beaconmutual.com

Make a copy of the completed form

You will want to make a copy of the PJD form and **Keep it on file for future use.**

Need Help?

If you have any additional questions or require assistance, you can contact the adjuster, or call us at (401)825-2667 x 6156 or send an email to Beaconclaims@beaconmutual.com and ask for an Ergonomic Specialist in the Claims Department.



Regular Duty Physical Job Description (PJD) Form

(See the instructions on the last page if you need help completing this form.)

Employee Name: _____ Claim Number: _____

Regular Duty Job Title: _____

Department: _____ Company Name: _____

Briefly describe the Essential Job Duties below in 2-3 sentences.

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Work Schedule:

Hours per day	Days per week	Shifts	Overtime Hours	Break/Lunch Periods

Equipment/Tools Used: (check)

Computer	Telephone	Calculator	Head Set	Forklift (sit)	Forklift (stand)
Motor Vehicle	Power Hand Tools	Manual Hand tools	Manual Pallet Jack		
Step Ladder	Extension Ladder	Heavy Machinery	Tool belt		
Other:					

Safety Equipment Used: (check)

Glasses	Gloves	Ear Plugs	Suit	Knee Pads	Mask
Hard Hat	Boots	Other			

Work Pace Set by (check all that apply):

Self	Incentive/Piece Rate	Machine	Quota System
Other:			

Environmental Exposures: (check)

Indoor Work	Outdoor Work	Extreme high Temps	Extreme low temps.
Other:			

Sitting, Standing, and Walking Requirements

a. TOTAL hours during a typical work day to: (check the correct number of hours)

• Sit	0.5	1	2	3	4	5	6	7	8+
• Stand	0.5	1	2	3	4	5	6	7	8+
• Walk	0.5	1	2	3	4	5	6	7	8+

- b. Has option to alternate sit/stand? Yes No Sometimes
- c. Maximum **sitting** time before changing positions? _____
- d. Maximum **standing** time before changing positions? _____

Functional Work Postures

Instructions: In terms of an 8 hour workday, select the category that applies to each activity.
Total hours in all columns may be greater than 8 hours:

Activity		Not at all	Occasional (< 2.5 hours)	Frequent (2.5 to 5.5 hours)	Constant (5.5 to 8 hours)	Explain/Comments
Bend/stoop						
Ladder Climb						
Kneel						
Balance						
Push/Pull						
Squat						
Crawl						
Stair Climb						
Reaching:	Above shoulder					
Indicate if using Right (R), Left (L) Both (B) extremities	Waist to shoulder					
	Below waist					
Grasp with whole hand	Right hand					
	Left hand					
	Both					
Pinching	Right hand					
	Left hand					
	Both					
Feeling (sensing temperatures and textures)	Right hand					
	Left hand					



Material Handling Requirements: (Include the **Weight of Objects)**

Instructions: **For every activity performed, enter the weight of the object, and select how often the lift/carry is performed within an 8-hour day.**

Activity	Weight In Pounds	Not at all	Occasionally 1 lift per hour	Frequently 2-12 lifts per hour	Constantly > 13 lifts per hour
Lift (usual load)					
Lift (max. load)					
Lift (max. lift above shoulder)					
Lift (max. lift below knee)					
Carry (usual load front carry)					
Carry (max. load front carry)					
Carry: (usual load bucket carry)					
Carry: (max. load bucket carry)					
Carry: (usual load shoulder carry)					
Carry: (max. load shoulder carry)					

In Summary:

What is the average amount of weight an employee is required to lift? _____ Lbs.

How Often? _____

What is the maximum amount of weight an employee is required to lift? _____ Lbs.

How Often? _____

Who is filling out this form?

Name:	
Job Title:	
Telephone:	
Email:	
Date:	
Signature:	

Please return this form to **Beacon Mutual by fax to 401-825-2980**. If you have any additional questions or require assistance, you can contact the adjuster, or call 825-2667 ext. 6156 or send an email to Beaconclaims@beaconmutual.com and ask for an Ergonomic Specialist in the claims department to assist you.



Modified Duty Options Form

Regular Duty Job Title: _____ Employee Name: _____

Company Name: _____ Claim Number: _____

Our Company can offer modified and/or transitional duty Yes No

We are a participant of the Beacon Mutual Stay at Work/Return to Work Program? Yes No

If no, would you like someone from Beacon to contact you to discuss the program in more detail? Yes No

Normal work hours/shift: _____

Common Modified Duty Options

Please check all that apply:

Any modifications or restrictions can be accommodated.

Work hours/shifts can be reduced or modified.

Sedentary desk/office work is available.

Patient transfers can be minimized or eliminated.

Lifting/Carrying can be eliminated or limited to _____

Option to alternate sit/stand.

Co-worker assistance can be utilized.

Stretch breaks as needed.

Work remotely from home.

Other

Please list or describe below any other accommodations your company will allow:

Please return to this form to **Beacon Mutual by fax to 401-825-2980**. If you have any additional questions or require assistance, you can contact the adjuster, or call 825-2667 ext. 6156 or send an email to Beaconclaims@beaconmutual.com and ask for an Ergonomic Specialist in the claims department to assist you.

Appendix A Direct Patient/Client Care

Regular Duty Job Title: _____ **Employee Name:** _____

Department: _____ **Company Name:** _____

Patient lifts/transfers:

Instructions: Please fill in the boxes below by marking all that apply

Physical Effort Provided By The Employee	Not at all	Supervision	Contact Guard	Minimum Assist <25% the work	Moderate Assist <50% of the work	Maximum Assist <75% of the work	Total Assist < 100%
BED MOBILITY							
Rolling							
Scouting							
Supine to Sit							
Repositioning							
TRANSFERS							
Sit-to-Stand							
Slide Board							
Hoyer Lift							
MOBILITY							
Ambulation Assist							
Maneuver wheelchair							

Questions

- a. Is the employee required to work independently with patients? Yes No
- b. Are coworkers available to assist with all types of transfers and mobility? Yes No
- c. Are patient restraints required at times? Yes No

Please explain the type and frequency of restraints in this box, if applicable, and/or provide any additional information:

Equipment Used: (check all that apply)

☐ Hoyer Lift
 ☐ Wheelchair
 ☐ Gait Belt
 ☐ Slide Board
 ☐ Sit Stand Device
☐ Electric Hospital Bed
 ☐ Manual Hospital Bed