

JOB ANALYSIS Disability Claim

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

Section 1 Employer Identification

| | | |
|-----------------------|--|------------------|
| Employer/Company Name | Plan Name (if different from Employer) | Policy ID Number |
|-----------------------|--|------------------|

Section 2 Employee (Member) Identification

| | | |
|--|-----------|---|
| Employee (Member) Name (Last, First, Middle Initial) | Job Title | Start date of the current position (yyyy-mm-dd) |
|--|-----------|---|

Regular Work Schedule: Total hours worked, each week: _____ Number of days/shifts worked, each week: _____
 Usual scheduled work days, each week: Monday Tuesday Wednesday Thursday Friday Saturday Sunday
 Usual scheduled work hours, each shift: _____ a.m. / p.m. to _____ a.m. / p.m.
**If this position requires a varied schedule or rotational shifts, please provide details.*

Section 3 Job Description (Regular Duties)

Provide details of the essential tasks/activities performed by this employee on a regular and/or daily basis. (list most important first)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Section 4 Job Requirements (Physical Tasks)

Provide details of the physical tasks performed by this employee.

| TABLE 1 ACTIVITY | For each activity please indicate: | | | FREQUENCY | | | % OF TIME ON TASK | | |
|---|------------------------------------|--|--|----------------------------|----------------------------|----------------------------|--------------------------|--------------------------|--------------------------|
| | N/A | TASK IS ESSENTIAL TO JOB <input type="checkbox"/> Yes <input type="checkbox"/> No | TASK COULD BE MODIFIED <input type="checkbox"/> Yes <input type="checkbox"/> No | Daily (D) | Weekly (W) | Monthly (M) | 0 to 33% | 34 to 66% | 67 to 100% |
| Sitting | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Standing | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stairs and/or Steps | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reaching - overhead | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reaching - must lean forward or to the side | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crawling and/or Climbing | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bending and/or Crouching | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kneeling and/or Squatting | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fine Manipulation and/or Gripping Objects | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Repetitive Body Motions | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D | <input type="checkbox"/> W | <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Is the employee able to change body positioning as comfort requires: Yes No Comments: _____

| TABLE 2 ACTIVITY | For each activity please indicate: | | | | FREQUENCY = Daily (D) Weekly (W) Monthly (M) | | | |
|---------------------|------------------------------------|---|---|---|---|--|--|--|
| | N/A | 0-10 LBS FREQUENCY, DURATION | 11-20 LBS FREQUENCY, DURATION | 21-50 LBS FREQUENCY, DURATION | >50 LBS FREQUENCY, DURATION | | | |
| Lifting | <input type="checkbox"/> | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | | | |
| Carrying | <input type="checkbox"/> | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | | | |
| Pushing/Pulling | <input type="checkbox"/> | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M, ___ hrs/shift | | | |

To complete job tasks; lift, carry, push, or pull assistive devices are: Required Available Not Required
 Comments: _____

Section 5 Job Requirements (Cognitive Tasks)

Provide details of the cognitive tasks performed by this employee.

| ACTIVITY | N/A | TASK IS ESSENTIAL TO JOB | TASK COULD BE MODIFIED | FREQUENCY | | | % OF TIME ON TASK | | |
|---|--------------------------|--|--|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | | | | Daily (D) | Weekly (W) | Monthly (M) | 0 to 33% | 34 to 66% | 67 to 100% |
| Understand, remember, and carry out detailed instructions | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maintain attention and concentration for extended periods | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Perform activities within a schedule | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Work involves pressure to meet deadlines | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Juggle tasks and prioritize work | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sustain an ordinary routine without supervision | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Make simple decisions or solve straightforward problems | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Solve complex problems | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Work alone or independently | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Work in a team or with others | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Interact with the general public or customers | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Respond to frequent changes in the environment or tasks | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Travel in unfamiliar places or use public transportation | <input type="checkbox"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Section 6 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, odours, non-toxic dust, exposure to marked temperature or humidity, etc.)

Section 7 Other Information (Accommodation)

Before the employee stopped working, did the injury or illness cause him/her to change the following:

| | DATE OF CHANGE (yyyy-mm-dd) | EXPLANATION OF CHANGE |
|--|--------------------------------|-----------------------|
| Job Duties <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | | |
| Job Performance <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | | |
| Use of Equipment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | | |
| Hours of Work <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | | |
| Attendance <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | | |

Has your employee had more than one job with your company? Yes No If yes, list all job titles and time spent at each job:

Based on your employee's skills, please comment on any opportunity for alternate job placement within your company:

Section 8 Declaration and Signature

I hereby declare that the information provided on this form is true and complete to the best of my knowledge and belief.

| | |
|---------------------------|-------------------------|
| Name (please print) | Position/Title |
| Phone (include area code) | Fax (include area code) |
| Signature | Date (yyyy-mm-dd) |

