Completing the Physical Job Description Form

Please complete the **Physical Job Description Form (PJD).** Your response is required so that medical providers can make informed decisions about your employee's ability to stay at work or return to work (with or without accommodations) and design meaningful treatment plans toward that end.

Instructions:

- ☐ **Regular Duty Job Description** (pages 2-4). Please provide key information about the physical demands of the job. Enter "n/a" for items that are not applicable.
- ☐ **Modified Duty** (pages 5-6). Please provide job accommodations that will allow employees to stay at work or return to work, as long as their job tasks stay within the parameter of any medical restrictions. Your Claims representative can help you develop modified duty options.
- ☐ **Direct Care/Client Care** (page 7). Complete this section only if your employee works in direct contact with patients, residents, or clients, i.e. hospital, group home, childcare.

Attach a copy of your company's current job description.

Return this form to Beacon Mutual by fax to 401-825-2980 or email back to your assigned claims adjuster as soon as possible.

Keep a copy of all forms for your records.

If you have any additional questions or require assistance, please contact the claim adjuster or send an email to: Beaconclaims@beaconmutual.com

For more information about Beacon's Stay-at-Work/Return-to-Work Program, visit: https://www.beaconmutual.com/employers/saw-rtw/

Thank you for being a Beacon Mutual Insurance Company customer!

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Regular Duty Physical Job Description (PJD) Form

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

Employee Name: _____ **Date of Birth:** _____ **Claim Number:** _____

Regular Duty Job Title: _____

Department: _____ **Company Name:** _____

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

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: Indicate if using Right **(R),** Left **(L)** Both **(B)** extremities	Above shoulder	☐	☐	☐	☐	
	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.

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Modified Duty Options Form

Employee Name: _____ **Date of Birth:** _____ **Claim Number:** _____

Company Name: _____

Please fill out the modified duty form below to assist your injured worker to either remain or return to the workplace safely.

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

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 job tasks your company will allow:

Example: Inventory: Count and label parts in shop or warehouse. May require handwriting or computer input of inventory parts. Involves standing, stooping, bending, climbing a ladder, pushing, pulling, lifting up to 10 lbs.
1. Task
2. Task
3. Task
4. Task
5. Task

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Modified duty work hours/days available: _____ **Hrs/day** _____ **Days/wk.**

Employee Name: _____ **Date of Birth:** _____ **Claim Number:** _____

Company Name: _____

Company No: _____ **Employer Contact:** _____ **Employer Fax:** _____

Employer Email: _____

Employer Instructions:

Please return to this form to your claims representative by email or by fax at 401-825-2980.
If you have any additional questions or require assistance, please contact your claims representative.

Physician Comments on patient's ability to perform the above job tasks ☐ Agree ☐ Disagree

Additional Comments:

_____

_____

_____

Physician Signature: _____ **Date:** _____

Medical Providers:

If applicable, please fax this completed Modified Duty Options Form (page 5-6) to the Beacon Mutual Insurance Company.

Claims Department: Fax 401-825-2980

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Appendix A

Direct Patient/Client Care

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

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	☐	☐	☐	☐	☐	☐	☐
Scooting	☐	☐	☐	☐	☐	☐	☐
Supine to Sit	☐	☐	☐	☐	☐	☐	☐
Boosting	☐	☐	☐	☐	☐	☐	☐
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 Available: (check all that apply)

☐ Patient Lift ☐ Wheelchair ☐ Gait Belt ☐ Slide Board ☐ Sit-to-Stand
☐ Device Electric Hospital Bed ☐ Manual Hospital Bed