

Name of Employee: _____ SUID: _____ Home Phone: _____

Department: _____ Job Title: _____

Today's Date: _____ Last Day Worked: _____

Department Job Analysis: Brief description of job tasks to be completed by supervisor:

Chemical, Tools, Equipment, Machines Used:

Physical Demands: Based on percentage of time required during the day, please note frequency as follows:

Constant (up to 100%)

Occasional (10% to 33%)

Never (0%)

Frequent (34% to 67%)

Rare (Less than 10%)

Standing		Stooping		Twisting		Reaching Forward	
Walking		Kneeling		Climbing Stairs		Concentration	
Sitting		Crouching		Reaching Overhead		Work/Deadline Pressures	
Pushing		Crawling		Handling/Fingering		Typing/Keying	
Balancing							

Lifting and Carrying: Indicate the maximum amount of weight the employee is expected to handle by placing an X in the appropriate box.	10 lbs	20 lbs	50 lbs	75 lbs	100 lbs
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Type of Leave:

NYS Disability or Workers Compensation - Contact Risk Management at 315.443.4011 (Fax: 315.443.1154)

Salary Continuation - Contact HR Service Center at 315.443.4042 (Fax: 315.443.1063)

Supervisor Name: _____

Contact Number: _____

Signature _____

Date _____

Physician's Assessment:

I have reviewed the above employee's job requirements and my patient is:

Approved to return to work on: _____ (date)

Approved to return to work with modifications as follows:

Duration of modifications: _____ (through date)

Not approved to return to work until: _____ (targeted return to work date)

Physician's Signature _____ Date: _____

NOTE: The physician's office must fax this form to the appropriate department as noted above.