



State of California  
 Division of Workers' Compensation  
 Retraining and Return to Work Unit

# DESCRIPTION OF EMPLOYEE'S JOB DUTIES

DWC-AD 10133.33

**INSTRUCTIONS:** This form shall be developed jointly by the employer and employee and is intended to describe the employee's job duties. The completed form will be reviewed to determine whether the employee is able to return to work.

EMPLOYEE NAME:	(LAST)	(FIRST)	(M.I.)	CLAIM#:
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EMPLOYER NAME:	JOB ADDRESS:
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JOB TITLE:	HRS. WORKED PER DAY:	HRS. WORKED PER WEEK:
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DESCRIPTION OF JOB RESPONSIBILITIES: (DESCRIBE ALL JOB DUTIES)

Please check one:  Regular Duty  Modified Duty  Alternative Work

1. Check the frequency of activity required of the employee to perform the job.

ACTIVITY (Hours per day)	NEVER 0 hours	OCCASIONALLY up to 3 hours	FREQUENTLY 3 - 6 hours	CONSTANTLY 6 - 8+ hours
Sitting				
Walking				
Standing				
Bending (neck)				
Bending (waist)				
Squatting				
Climbing				
Kneeling				
Crawling				
Twisting (neck)				
Twisting (waist)				
Hand Use: Dominant hand Right-- Left---				
Is repetitive use of hand required?				
Simple Grasping (right hand)				
Simple Grasping (left hand)				
Power Grasping (right hand)				
Power Grasping (left hand)				
Fine Manipulation (right hand)				
Fine Manipulation (left hand)				
Pushing & Pulling (right hand)				
Pushing & Pulling (left hand)				
Reaching (above shoulder level)				
Reaching (below shoulder level)				
Keyboarding with both hands				

2. Please indicate the daily Lifting and Carrying requirements of the job: Indicate the height the object is lifted from floor, table or overhead location and the distance the object is carried .

	LIFTING				Height	CARRYING				Distance
	Never 0 hrs	Occasionally up to 3 hrs	Frequently 3-6 hrs.	Constantly 6-8+ hrs.		Never 0 hrs.	Occasionally up to 3 hrs.	Frequently 3-6 hrs.	Constantly 6-8+ hrs.	
0-10 lbs.										
11-25 lbs.										
26-50 lbs.										
51-75 lbs.										
76-100lbs.										
100+ lbs.										

Describe the heaviest item required to carry and the distance to be carried: \_\_\_\_\_

3. Please indicate if your job requires:

	YES	NO	(IF YES, PLEASE BRIEFLY DESCRIBE)
a. Driving cars, trucks, forklifts and other equipment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Working around equipment and machinery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Walking on uneven ground?	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Exposure to excessive noise?	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Exposure to extremes in temperature, humidity or wetness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Exposure to dust, gas, fumes, or chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
g. Working at heights?	<input type="checkbox"/>	<input type="checkbox"/>	_____
h. Operation of foot controls or repetitive foot movement?	<input type="checkbox"/>	<input type="checkbox"/>	_____
i. Use of special visual or auditory protective equipment?	<input type="checkbox"/>	<input type="checkbox"/>	_____
j. Working with bio-hazards such as: blood borne pathogens, sewage, hospital waste, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____

Employee Comments:

Employer Comments:

EMPLOYER CONTACT NAME:

EMPLOYER CONTACT TITLE:

EMPLOYER REPRESENTATIVE SIGNATURE:

DATE:

EMPLOYEE'S SIGNATURE:

DATE: