VOCATIONAL HISTORY / JOB DESCRIPTION

PATIENT NAME: _____JOB TITLE: _____

EMPLOYER: _____SUPERVISOR: _____

EMPLOYERS PHONE: _____

Are you presently working? □ Yes □ No

If yes, are you working: □ Full Duty _____ hours daily.

□ Light / Modified Duty _____ hours daily

If no, is there a job to return to? □ Yes □ No

Please explain: _____

Does your employer accept restrictions or limited hours? □Yes □ No

If you are not working, how long have you been off work? _____

Do you want to return to your Full duty position? □ Yes □ No

If no, please explain? _____

What is the maximum weight you are required to lift at Full Duty? _____

What physical requirements of your job are you particularly concerned with?

When is your next appointment with your doctor? _____

Patient signature: _____ Date: _____