State of California
Division of Workers' Compensation

DESCRIPTION OF EMPLOYEE'S JOB DUTIES

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 by the treating doctor to determine whether the employee is able to return to his/her job. This is an important document and should accurately show the requirements of the employee's job. If the employee needs help in completing this form, the employee may contact the Information and Assistance Officer at the Division of Workers' Compensation. The phone number can be found in the State Government section of the phone book.

EMPLOYEE NAME: (LAST) (FIRST) (M.I.)

CLAIM #:

EMPLOYER NAME:

JOB ADDRESS:

JOB TITLE:

HRS. WORKED PER DAY:

HRS. WORKED PER WEEK:

DESCRIPTION OF JOB RESPONSIBILITIES: (DESCRIBE ALL JOB DUTIES)

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)				

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					CARRYING				
	Never 0 hours	Occasionally up to 3 hours	Frequently 3–6 hours	Constantly 6–8+ hours	Height	Never 0 hours	Occasionally up to 3 hours	Frequently 3–6 hours	Constantly 6–8+ hours	Distance
0–10 lbs.										
11–25 lbs.										
26–50 lbs.										
51–75 lbs.										
76–100 lbs.										
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?	☐	☐	____
b. Working around equipment and machinery?	☐	☐	____
c. Walking on uneven ground?	☐	☐	____
d. Exposure to excessive noise?	☐	☐	____
e. Exposure to extremes in temperature, humidity or wetness?	☐	☐	____
f. Exposure to dust, gas, fumes, or chemicals?	☐	☐	____
g. Working at heights?	☐	☐	____
h. Operation of foot controls or repetitive foot movement?	☐	☐	____
i. Use of special visual or auditory protective equipment?	☐	☐	____
j. Working with bio-hazards such as: bloodborne pathogens, sewage, hospital waste, etc.	☐	☐	____

Employee Comments:

Employer Comments:

EMPLOYER CONTACT NAME:	EMPLOYER CONTACT TITLE:
EMPLOYER REPRESENTATIVE SIGNATURE:	DATE:
EMPLOYEE'S SIGNATURE:	DATE:
QUALIFIED REHAB. REPRESENTATIVE SIGNATURE: (IF APPLICABLE)	DATE:

Rehabilitation Unit
California Division of Workers' Compensation

Form RU-91

DESCRIPTION OF EMPLOYEE'S JOB DUTIES

Purpose:
To obtain a job description which is to be forwarded to the employee's treating physician when an injury or illness results in disability exceeding 90 days.

Submitted by:

1. Qualified Rehabilitation Representative, if the injury is before 1/1/94, or
2. Claims Administrator if the injury is on or after 1/1/94.

When prepared:
If the injury is before 1/1/94, the QRR meets with the employee to jointly complete this form and provides a copy of the form in conjunction with the RU-90 to the employee's treating physician. If the injury is on or after 1/1/94, the claims administrator consults with the injured worker in completing the RU-91 and then submits it to the treating physician.

When submitted:
To the treating physician. **Do not file the RU-90 or RU-91 with the Rehabilitation Unit unless specifically requested or when submitting information as part of a dispute.**

Form completion:
Qualified Rehabilitation Representative or claim administrator, in consultation with the employee and employer, completes the entire form.

Accompanying document:
The RU-91 is to be attached to the RU-90 and submitted to the treating doctor.

Rehabilitation Unit action:
None.