

**OWNER CONTROLLED INSURANCE PROGRAM  
INSURANCE COST INFORMATION WORKSHEET**

All Contractors, Subcontractors, and Sub-subcontractors of every tier, are required to complete this worksheet and submit as part of your bid.

*Note: It is suggested that you examine your current Policies and contact your Insurance Broker before answering the following questions.*

**Project:** \_\_\_\_\_

1. Contractor/Subcontractor/Sub-subcontractor: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Federal ID#: \_\_\_\_\_ 3a. Work Comp Bureau ID#: \_\_\_\_\_
4. Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_
5. Contact Name: \_\_\_\_\_

**Bid Package (Name and Number):** \_\_\_\_\_

- 6a. Contract Amount: \$ \_\_\_\_\_ 6b. Amount of Self Performed Work: \$ \_\_\_\_\_
7. Description of Work: \_\_\_\_\_
8. Awarding Contractor: \_\_\_\_\_
9. Claim Retention or Deductible Amounts (if greater than \$5,000): WC \_\_\_\_\_ GL \_\_\_\_\_

**A. Workers Compensation Estimated Payrolls/Premiums (attach separate sheet if necessary):**

(1) Workers Compensation Classification(s)	(2) WC Class Code(s)	(3) Man-hours by Class Code	(4) Estimated Payroll	(5) Workers Compensation Premium Rate	(6) Workers Compensation Premium
Totals=>>					\$ _____

MODIFICATIONS TO WORKERS COMPENSATION PREMIUM	FACTOR	CHARGE	PREMIUM
A. Estimated Total Premium (All Class Codes)			
B. Increased Limit Factor-ILF (x A)			
C. Experience Modification Factor or Merit Rating Credit (A+B) X C			
D. Deviation (x C)			
E. Construction Credit (x C)			
F. Standard Premium (C+D+E)			
G. Premium Discount (x C)			
H. Deductible Credit (x C)			
I. Scheduled Credit (x C)			
J. Terrorism Risk Insurance Act			
K. Other Applicable Factor			
L. Second Injury Fund			
M. Work Comp Funds Assessment			
N. State Specific Surcharge			
O. WC Loss Fund* (Form 1A – line e)			
<b>P.</b>	<b>TOTAL WORKERS COMPENSATION PREMIUM</b>		

*\*if WC is provided under large deductible, retrospectively rated or other loss sensitive program, contractor is required to complete Form 1A to determine WC Loss Fund for the bid.*

**B. Commercial General Liability**

Rating Basis:  Payroll  Contract Value  Other: \_\_\_\_\_  
 Per \$100  per \$1,000

GL Classification	GL Code	GL Rate	GL Payroll/Contract Value	Premium
			\$	\$
			\$	\$
<b>TOTAL:</b>			(B1) \$	(B2) \$

**C. Commercial Umbrella/Excess Liability**

Classification	Code	Rate	Payroll/Contract Value	Premium
			\$	\$
			\$	\$
<b>TOTAL:</b>			(C1) \$	(C2) \$

**D. Builders Risk and Installation Floater**

Rating Basis:  Per \$100 Contract Value  Per \$1,000 Contract Value  Other: \_\_\_\_\_

Rate: \_\_\_\_\_ Contract Value: \_\_\_\_\_ Premium: \_\_\_\_\_  
(D1) (D2) (D1) x (D2)

**E. Total Insurance Premiums (A+B+C+D)**

\$ \_\_\_\_\_

**F. Overhead & Profit on Insurance Premiums:**

15 % \$ \_\_\_\_\_  
(F1) (F1) x E

**G. Total Insurance Credit (D+E):**

\$ \_\_\_\_\_

**Contractor/Subcontractor Insurance Credit Rate: (G/6b)**

\_\_\_\_\_

**H. ADDITIONAL DOCUMENTS REQUIRED:**

The following information must be provided along with this form:

- Work Comp declaration page and rating pages
- Experience Modification Worksheet from NCCI (or applicable) Bureau
- General Liability declaration page and rating pages
- Umbrella Liability declaration page and rating pages
- 5 Years of GL and WC loss runs for any policy with a deductible / retention greater than \$2,500.
- 5 years of audited payrolls and GL exposures (payroll/receipts) for applicable policies with deductibles greater than \$5,000
- Form 1B for any contractor who has subcontracted to work to other contractors or plans to subcontract work.

**WARRANTY**  
(If Enrolled in OCIP)

Regarding Workers Compensation, General Liability and Umbrella/Excess Liability: These coverages, as stated in the Contract Documents are provided by the Owner. The undersigned agrees and warrants:

- The Contractor certifies that they have identified in their bid the Contractor's cost for the Workers' Compensation, General Liability and Umbrella/Excess Liability Coverages that are being provided and paid for by the Construction Manager. The contractor gives the Owner authority to audit its records for verification and to adjust the "Total Insurance Credit" and "Contractor Insurance Credit Rate", and collect any additional money associated with the adjustment, based on the actual payrolls incurred to complete the contract.
- It is the Contractor's responsibility to notify their insurance carrier as to the existence of an Owner Controlled Insurance Program for this project and to amend their insurance policies accordingly.
- The statements in this insurance application are true to the best of my knowledge.
- The cost of the premiums for the non-OCIP insurance specified in the Contract will be paid for by the Contractor.
- Any and all returns of premium, dividends, discounts or other adjustments to any OCIP policy is assigned, transferred and given absolutely to the Owner. This assignment pertains to the OCIP policies as now written and as subsequently modified, rewritten or replaced, including any additional amounts or coverages as a result thereof. Rights of cancellation of all insurance policies provided to Contractor are also assigned to the Owner. This assignment is only valid for insurance policies whose premiums have been paid by the Owner on behalf of such Contractors.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

(please print)

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

**OWNER CONTROLLED INSURANCE PROGRAM  
LOSS RATE CALCULATION WORKSHEET**

Note: This is to be completed if contractor maintains WC or GL coverage subject to deductible in excess of \$5,000

Project: \_\_\_\_\_

1. Contractor/Subcontractor/Sub-subcontractor: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Federal ID#: \_\_\_\_\_ 3a. Work Comp Bureau ID#: \_\_\_\_\_
4. Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_
5. Contact Name: \_\_\_\_\_

**Bid Package (Name and Number):** \_\_\_\_\_

- 6a. Contract Amount: \$ \_\_\_\_\_ 6b. Amount of Self Performed Work: \$ \_\_\_\_\_
7. Description of Work: \_\_\_\_\_
8. Awarding Contractor: \_\_\_\_\_
9. Claim Retention or Deductible Amounts (if greater than \$5,000): WC \_\_\_\_\_ GL \_\_\_\_\_

**I. WC Loss Rate Calculation (if Applicable)**

Description	2009-10	2010-11	2011-12	2012-13	2013-14	Total
Gross WC Losses <sup>1</sup>						
Net WC Losses <sup>2</sup>						
Loss Development Factor (LDF)	1.20	1.30	1.40	1.75	2.50	
Adjusted Net WC Losses <sup>3</sup> (= Net WC Losses x LDF)						(a)
Payroll <sup>4</sup>						(b)

1. List total incurred losses for each of the past 5 policy periods.
2. Each loss in excess of the applicable deductible shall be limited to determine "Net WC Losses". Supporting carrier generated loss runs valued within 60 days of bid date must be provided.
3. For each policy period, multiply "Net WC Losses" by LDF, enter result. Sum and enter result as (a).
4. Enter total field payroll for each policy period. Sum and enter result as (b)

**WC Loss Rate (a / b)** (c)  
**Projected Payroll for Project** (from Form 1 – line A4) (d)  
**WC Loss Fund (c x d)** (e)

**II. GL Loss Rate Calculation (if Applicable)**

Description	2009-10	2010-11	2011-12	2012-13	2013-14	Total
Gross GL Losses <sup>1</sup>						
Net GL Losses <sup>2</sup>						
Loss Development Factor (LDF)	1.20	1.30	1.40	1.75	2.50	
Adjusted Net GL Losses <sup>3</sup> (= Net GL Losses x LDF)						(a)
Construction Value (CV) / Payroll <sup>4</sup>						(b)

1. List total incurred losses for each of the past 5 policy periods.
2. Each loss in excess of the applicable deductible shall be limited to determine "Net GC Losses". Supporting carrier generated loss runs valued within 60 days of bid date must be provided.
3. For each policy period, multiply "Net WC Losses" by LDF, enter result. Sum and enter result as (a).
4. Enter total field payroll or CV as appropriate for each policy period. Sum and enter result as (b)

**GL Loss Rate (a / b)** (c)  
**Projected CV/Payroll for Project** (from Form 1 – line B1) (d)  
**GL Loss Fund (c x d)** (e)

Fax To: Daria Ward  
The Graham Company  
215-599-9936  
  
E-Mail To: kilgarriff\_unit@grahamco.com

Mail To: Daria Ward  
The Graham Company  
The Graham Building  
One Penn Square West  
Philadelphia, PA 19102

**OWNER CONTROLLED INSURANCE PROGRAM  
LOSS RATE CALCULATION WORKSHEET**

Note: This form is to be completed by any contractor who intends to subcontract any portion of the work to be performed under contract

**Project:** \_\_\_\_\_

1. Contractor/Subcontractor/Sub-subcontractor: \_\_\_\_\_
2. Address: \_\_\_\_\_
3. Federal ID#: \_\_\_\_\_ 3a. Work Comp Bureau ID#: \_\_\_\_\_
4. Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_
5. Contact Name: \_\_\_\_\_

**Bid Package (Name and Number):** \_\_\_\_\_

- 6a. Contract Amount: \$ \_\_\_\_\_ 6b. Amount of Self Performed Work: \$ \_\_\_\_\_
7. Description of Work: \_\_\_\_\_
8. Awarding Contractor: \_\_\_\_\_

Contracting Parties & Trades		Proposed Subcontract Amount	Estimated Man-hours	Estimated Payroll	Initial Insurance Cost
Subcontractors which have been identified					
Additional Trade Packages for which subcontractor has not been identified	List by Trade or Function:				
Total for Contract:				a	b
Composite Insurance Cost Rate for Contract: (a ÷ b x 100)					

**ENROLLMENT FORM**  
**YALE UNIVERSITY**  
**OWNER CONTROLLED INSURANCE PROGRAM**  
**Request for Insurance**

**Construction Manager/Contractor/Subcontractor/Sub-subcontractor Information Form**

COVERAGE IS NOT APPLICABLE UNTIL THIS FORM IS SUBMITTED TO AND APPROVED BY THE GRAHAM COMPANY. PLEASE FAX OR E-MAIL THIS FORM PRIOR TO STARTING WORK TO: THE GRAHAM COMPANY, THE GRAHAM BUILDING, ONE PENN SQUARE WEST, PHILADELPHIA, PA 19102,  
ATTN: Daria Ward - FAX #215-599-9936 or e-mail: kilgarrieff\_unit@grahamco.com

**GENERAL**

1. Company Name: \_\_\_\_\_
2. Company Address: \_\_\_\_\_  
\_\_\_\_\_
3. Telephone: Area Code ( ) No: \_\_\_\_\_
4. Federal Employer ID # \_\_\_\_\_
5. Dun & Bradstreet #: \_\_\_\_\_

**CONTRACT INFORMATION**

6. Project: \_\_\_\_\_
7. Contract No: \_\_\_\_\_
8. Date Contract Awarded: \_\_\_\_\_

9.

	Project Site Representative	Insurance/Risk Manager	Claims Contact
Name:	_____	_____	_____
Address:	_____	_____	_____
Telephone:	_____	_____	_____
Fax Number:	_____	_____	_____
E-Mail Address:	_____	_____	_____

10. Brief Description of Work To Be Done: \_\_\_\_\_  
\_\_\_\_\_
11. Estimated Start Date of Jobsite Activities: \_\_\_\_\_
12. Estimated Completion Date of Jobsite Activities: \_\_\_\_\_

**WORKERS COMPENSATION DATA**

Classification	Class Code	Payroll*	Manhours*

\* Include only the estimated jobsite payrolls (manhours) under this contract to be directly performed by your company (and not by your subcontractors) for the period coverage is to be provided. In addition, please identify total expected payroll for all anticipated contracts for this project: \_\_\_\_\_

16. Workers Compensation Exp. Modification: \_\_\_\_\_  
Anniversary Rating Date \_\_\_\_\_
17. Location of payroll records: \_\_\_\_\_  
Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_
18. Estimated Contract Amount: \$ \_\_\_\_\_
19. Estimated Total Contract Amount for All Anticipated Contracts for this Project: \_\_\_\_\_

20. PRESENT INSURANCE COVERAGE

	<u>Workers Compensation</u>	<u>Commercial General Liability</u>	<u>Business Automobile</u>	<u>Commercial Umbrella Liability</u>
Insurer:	_____	_____	_____	_____
Policy No.:	_____	_____	_____	_____
Broker:	_____	_____	_____	_____
Address:	_____	_____	_____	_____
	_____	_____	_____	_____
Account Executive:	_____	_____	_____	_____
Telephone #:	_____	_____	_____	_____

21. Your status on this project:  
 Construction Manager       Contractor       Subcontractor
22. If you are a Subcontractor, please indicate who you are working for: \_\_\_\_\_
23. If your firm anticipates that work to be done under your contract will be subcontracted to others, indicate the names and addresses of the firms which will act as your subcontractors (attach additional pages, if necessary):

<u>Subcontractor</u>	<u>Contact Person</u>	<u>Phone Number</u>	<u>Subcontract \$</u>

24. Will your work under this contract be completed in part at any offsite location entirely dedicated to this project? If yes, describe work and provide address of offsite location: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
25. Will your work under this contract include the use of aircraft or watercraft? If so, please describe:  
 \_\_\_\_\_  
 \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 (please type or print)

\_\_\_\_\_  
 Signature Title

**Yale University OCIP**  
**OWNER CONTROLLED INSURANCE PROGRAM**  
**ASSIGNMENT BY CONSTRUCTION MANAGER, CONTRACTOR OR**  
**SUBCONTRACTOR**

In consideration of Yale University's agreement to arrange and provide insurance under an Owner Controlled Insurance Program and for other good and valuable consideration, we hereby assign to Yale University all rights of cancellation, return premiums, premium refunds, and any other monies due or to become due in connection with the Owner Controlled Insurance Program.

\_\_\_\_\_  
Name of Construction Manager, Contractor or Subcontractor

\_\_\_\_\_  
By

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

**YALE UNIVERSITY**  
**OWNER CONTROLLED INSURANCE PROGRAM**  
**NOTICE OF CONTRACT AWARD**

We have awarded a contract to the following Contractor/Subcontractor:

1. Project Name: \_\_\_\_\_
2. Contractor Name: \_\_\_\_\_
3. Address: \_\_\_\_\_
4. Phone Number: \_\_\_\_\_
5. Contact Person: \_\_\_\_\_
6. E-Mail Address: \_\_\_\_\_
7. Fax Number: \_\_\_\_\_
8. Estimated Start Date: \_\_\_\_\_
9. Estimated Completion Date: \_\_\_\_\_
10. Contract Number: \_\_\_\_\_
11. Description of Work: \_\_\_\_\_
12. Contract Amount: \_\_\_\_\_
13. Contractor: \_\_\_\_\_
14. Contact Person: \_\_\_\_\_

Prior to the Approved Contractor or Subcontractor being permitted on-site, The Graham Company must receive their Enrollment Forms.

Fax To:       Daria Ward  
                  The Graham Company  
                  215-599-9936

Mail To:       Daria Ward  
                  The Graham Company  
                  The Graham Building  
                  One Penn Square West  
                  Philadelphia, PA 19102  
                  E-Mail: kilgarriff\_unit@grahamco.com



**YALE UNIVERSITY**  
**OWNER CONTROLLED INSURANCE PROGRAM**  
**NOTICE OF WORK COMPLETION**

1. Contractor Name and ID#: \_\_\_\_\_
2. Project: \_\_\_\_\_
3. Contract #: \_\_\_\_\_
4. Work Performed: \_\_\_\_\_
5. Date work completed: \_\_\_\_\_

\_\_\_\_\_  
Signature

Fax To: Daria Ward  
The Graham Company  
215-599-9936

Mail To: Daria Ward  
The Graham Company  
The Graham Building  
One Penn Square West  
Philadelphia, PA 19102  
E-Mail: kilgarriff\_unit@grahamco.com

**YALE UNIVERSITY  
OWNER CONTROLLED INSURANCE PROGRAM  
FORM 6: MONTHLY PAYROLL REPORT**

Please list below your actual monthly wages expended by you for the preceding month. Refer to the instructions below for completing this form.

**FAX OR EMAIL TO: The Graham Company  
C/O: Daria Ward, CPCU , ARM, Assistant Account Manager  
1 Penn Square W Graham Bldg. Phila. Pa. 19102  
Fax No: 1-215-599-9936 or email: kilgarriff\_unit@grahamco.com**

Name of Contractor: \_\_\_\_\_ Project: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INSTRUCTIONS:**

- 1. Show the applicable Workers Comp Class Code in column 2. Use additional lines if more than one code applies.
- 2. Show the Description or Type of Work performed in column 3.
- 3. Show total Hours Worked on the Job Site during the period shown
- 4. Show total Straight-Time Payroll in column 4. This **includes** all Regular & Overtime pay at the Straight-Time Rate on the job site.

**MONTHLY PERIOD:** \_\_\_\_\_

WC CODE	DESCRIPTION OF WORK	HOURS WORKED	TOTAL STRAIGHT-TIME PAYROLL

I hereby certify that the wages above are the accurate wages for the period shown above.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(please type or print)

Signature: \_\_\_\_\_



**State of Connecticut  
Workers' Compensation Commission**

*Send this form to: Workers' Compensation Commission, 21 Oak Street, Hartford, CT 06106-8011*

Rev. 7-13-2009

# FRI

Date filed in Chairman's Office

## Employer's First Report of Occupational Injury or Illness

File pursuant to C.G.S. § 31-316 for injuries that result in INCAPACITY FOR ONE DAY OR MORE. Please TYPE or PRINT IN INK.

(for wee use only)

Employer (Name, Address & Zip)		Phone #	Carrier / Administrator Claim #		OSHA Log Case #	Report Purpose Code	
			Jurisdiction		Jurisdiction Claim #		
			Employer's Location Address (if different)		Phone #		
SIC Code	FEIN						
Carrier (Name, Address & Zip)		Phone #	Claims Administrator (Name, Address & Zip)		Phone #		
Policy / Self-Insured #		<input type="checkbox"/> Check, if Self-Insured	Policy Period (MMDDIYY)		FROM: TO:		
Employee: Last Name		First Name	Middle Name	Gender	Date Hired (MMDDIYY)	State of Hire	
D.O.B. (required)		Phone #		<input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation / Job Title		
Address (incl. Zip)					Rate of Pay \$	per	NCCI Class Code
				<input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Other			
Date of Injury / Illness (MMDDIYY)		Town of Injury / Illness		Physician / Health Care Provider (Name, Address & Zip)			
Time Employee Began Work		<input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Did Injury / Illness occur on Employer's Premises?		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Time of Occurrence		<input type="checkbox"/> cannot be determined <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Type of Injury / Illness		Hospital (Name, Address & Zip)		
Date Employer Notified (MMDDIYY)		Part of Body Affected					
Date Disability Began (MMDDIYY)		Type of Injury / Illness Code					
Date Last Worked (MMDDIYY)		Part of Body Affected Code					
Date Return(ed) to Work (MMDDIYY)		Were Safeguards or Safety Equipment provided?		Initial Treatment			
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No Medical Treatment <input type="checkbox"/> Emergency Care			
If Fatal, Date of Death (MMDDIYY)		If provided, were they used?		<input type="checkbox"/> Minor – by Employer <input type="checkbox"/> Hospitalized More Than 24 Hours			
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Minor – by Clinic / Hospital <input type="checkbox"/> Future Major Medical – Lost Time Anticipated			
All equipment, materials, and/or chemicals employee was using when accident or illness exposure occurred:		How Injury / Illness Occurred - Describe the sequence of events, including any objects or substances that directly injured the employee or made the employee ill:		Date Administrator Notified (MMDDIYY)		Date Prepared (MMDDIYY)	
Specific activity and/or work process employee was engaged in when accident or illness exposure occurred:							
Contact Name				Preparer's Name & Title		Phone #	
Phone #		Cause of Injury Code					

## JOB ANALYSIS FORM WITHOUT PHYSICIAN'S APPROVAL

<b>Employee's Name</b>				
<b>Job Title</b>				
<b>Industry</b>			<b>Union:</b>	
<b>Employer</b>	Name:			
	Address:			
	Contact Person:		Telephone Number:	
	Employment Considered: Unskilled ___ Semi-Skilled ___ Skilled ___			
<b>Job Description</b>	Essential Functions:			
	Other Functions:			
<b>Earnings</b>	Earnings:		Total Hours:	
	Hours:	Lunch:	Breaks:	
<b>Training/Education Requirements</b>				
<b>Machine/Tools/Equipment/Work Aides</b>				
<b>Working Conditions (Environmental)</b>	Inside: ___ Outside: ___ Both: ___			
	Cold: ___ Wet/Humid: ___ Noise/Vibrations: ___			
	Heat: ___ Hazards: ___ Fumes/Dust/Odor: ___			
<b>Physical Demands (Per Work Day)</b>	Never (N) Occasionally, 1-33% (O) Frequently, 34-66% (F) Continuously, 67-100% (C)			
	a. Standing:	Surface:	l. Crouching:	
	b. Walking:		m. Bending:	
	c. Sitting:		n. Crawling Distance:	
	d. Carrying:	Lbs.:	o. Reaching: Level:	
	e. Pushing:	Lbs.:	p. Handling:	
	f. Lifting:	Lbs.:	q. Simple Grasping:	
	g. Pulling:	Lbs.:	r. Firm Grasping:	
	h. Climbing:	Ht.:	s. Fine Manipulation:	
	i. Balancing:		t. Talking:	
	j. Stooping:		u. Seeing:	
	k. Kneeling:		v. Hearing:	
	<b>Repetitive Actions</b>	a. Feet: Right: ___ Left: ___ Both: ___ Operate Foot Controls		
		b. Hands: Right: ___ Left: ___ Both: ___ Operate Hand Controls		
<b>Other Information or Comments</b>				
<b>Analyst</b>	Name:	Date:	Time:	

## JOB ANALYSIS FORM WITH PHYSICIAN'S APPROVAL

<b>EMPLOYEE'S NAME</b>				
<b>JOB TITLE</b>				
<b>INDUSTRY</b>			Union:	
<b>EMPLOYER</b>	Name:			
	Address:			
	Contact Person:	Telephone Number:		
	Employment Considered: Unskilled _____ Semi-Skilled _____ Skilled _____			
<b>JOB DESCRIPTION</b>	Essential Functions:			
	Other Functions:			
<b>EARNINGS</b>	Earnings:	Total Hours:		
	Hours:	Lunch:	Breaks:	
<b>TRAINING/EDUCATION REQUIREMENTS</b>				
<b>MACHINE/TOOLS/EQUIPMENT/WORK AIDES</b>				
<b>WORKING CONDITIONS (ENVIRONMENTAL)</b>	Inside: _____ Outside: _____ Both: _____			
	Cold: _____ Wet/Humid: _____ Noise/Vibrations: _____			
	Heat: _____ Hazards: _____ Fumes/Dust/Odor: _____			
<b>PHYSICAL DEMANDS (PER WORK DAY)</b>	Never (N)    Occasionally, 1-33% (O)    Frequently, 34-66% (F)    Continuously, 67-100% (C)			
	a. Standing:	Surface:	l. Crouching:	
	b. Walking:		m. Bending:	
	c. Sitting:		n. Crawling      Distance:	
	d. Carrying:	Lbs.:	o. Reaching:      Level:	
	e. Pushing:	Lbs.:	p. Handling:	
	f. Lifting:	Lbs.:	q. Simple Grasping:	
	g. Pulling:	Lbs.:	r. Firm Grasping:	
	h. Climbing:	Ht.:	s. Fine Manipulation:	
	i. Balancing:		t. Talking:	
	j. Stooping:		u. Seeing:	
	k. Kneeling:		v. Hearing:	
	<b>REPETITIVE ACTIONS</b>	a. Feet:    Right: _____    Left: _____    Both: _____    Operate Foot Controls		
		b. Hands:    Right: _____    Left: _____    Both: _____    Operate Hand Controls		
<b>OTHER INFORMATION OR COMMENTS</b>				
<b>ANALYST</b>	Name:		Date:	
			Time:	

**PHYSICIANS' APPROVAL:** I have read the above Job Analysis, and based on my examination of

on \_\_\_\_\_, he/she is capable of performing these job duties. If he/she cannot perform the essential functions of the job, please state why. \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_