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| Return to Main Menu |  **Department of Natural Resources**  Georgia Activity Analysis | DNR SOP – **HR**508 Attachment #1 |

Use this form to conduct an analysis of a specific job. - Employee is responsible for providing healthcare provider with an authorization to release medical information.

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| --- | --- | --- |
| **EMPLOYEE NAME:**  | **WORK LOCATION:**  | **DATE COMPLETED:** **/** **/**  |
| **JOB TITLE:** | **COMPLETED BY (NAME/TITLE):** |
| 1. **PURPOSE OF JOB** (Describe in terms of desired outcomes, rather than in terms of how traditionally performed.):
 |
| 1. **JOB FUNCTIONS** (Describe below each essential duty/job function in order of frequency performed; and indicate primary physical, mental and environmental demands required to perform each function.):
 |
| Essential Duty/Job Function Description | Primary Demands |
| 1.  |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |
| **III. REQUIRED PRODUCTIVITY** (Describe or quantify output required of employee in this position, including quality of work requirements.): |
|  |
| **IV. WORK SCHEDULE REQUIREMENTS** [Describe any special qualifications required for this job, including the ability to work specific shifts (including rotating shifts)]: |
|  |
| V. HEALTHCARE PROVIDER COMMENTS (Check the appropriate box below and provide comments as necessary.) An appointment for a review is required if not fully released.\*  |
| * I release this employee to this job as described above.
* I release this employee to this job under the following:

 Temporary conditions/restrictions**\***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) OR  Permanent conditions/restrictions**\***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* I cannot release this employee to any part of this job at this time**\***. The medical rationale is as follows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **\***An appointment to review the employee's condition further is scheduled for (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If released to return to work, please indicate any prescribed medications and their side effects which may impact job performance (a separate sheet may be attached):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Healthcare Provider’s Signature:** | **Date Signed:** |
| **Print Name:** | **Telephone: ( )** |

8/2018