Physical Requirements of Position/Occupational Title

Instructions

This form must be completed by the member and their employer to supplement, if any, the physical requirements listed on the member's duty statement/job description. The employer must give the member a copy of this form once it has been completed and signed by both parties, then sends the original to CalPERS. The member must then attach their current duty statement/job description and the copy of the Physical Requirements of Position/Occupational Title to the Physician's Report on Disability prior to sending to their physician.

Member SSN / Member Name / Position/Occupational Title

Employer Name / Worksite Street Address / City / State / Zip

Indicate with a check mark (✓) the frequency required for each activity listed below.

Activity	Never	Occasionally Up to 3 hours	Frequently 3 – 6 hours	Constantly Over 6 hours	Distance/Height
Sitting					
Standing					
Walking					
Crawling					
Kneeling					
Climbing					
Squatting					
Bending (neck)					
Bending (waist)					
Twisting (neck)					
Twisting (waist)					
Reaching (above shoulder)					
Reaching (below shoulder)					
Pushing & Pulling					
Fine Manipulation					
Power Grasping					
Simple Grasping					
Repetitive use of hand(s)					
Keyboard Use					
Mouse Use					
Lifting/Carrying					
0 – 10 lbs.	/	/	/	/	/
11 – 25 lbs.	/	/	/	/	/
26 – 50 lbs.	/	/	/	/	/
51 – 75 lbs.	/	/	/	/	/
76 – 100 lbs.	/	/	/	/	/
100 + lbs.	/	/	/	/	/

PERS01M0050DMC (Rev. 11/04)

Member SSN / Member Name / Position/Occupational Title

Indicate with a check mark (✓) the frequency required for each activity listed below.

Activity	Never	Occasionally Up to 3 hours	Frequently 3 – 6 hours	Constantly Over 6 hours	Distance/Height
Walking on uneven ground					
Driving					
Working with heavy equipment					
Exposure to excessive noise					
Exposure to extreme temperature, humidity, wetness					
Exposure to dust, gas, fumes, or chemicals					
Working at heights					
Operation of foot controls or repetitive movement					
Use of special visual or auditory protective equipment					
Working with bio-hazards (e.g., blood-borne pathogens, sewage, hospital waste, etc.)					

Comments or additional requirements not listed above:

Signature of Employer Representative/Title **Date** **Phone Number** (_____)_____

Signature of Member **Date** **Phone Number** (_____)_____