Transitional Task Assignment Form (TTA)

To be completed by a district representative based on the most recent medical recommendations.

Date: _____ **Date of Medical Evaluation**: _____

Employee: _____ **Date of Next Office Visit**: _____

Please answer all questions to the best of your ability. If a question does not apply to the injury, leave it blank. Always defer to the most restrictive capabilities when there are multiple injuries.

A. Work Status:

Capable of usual job? ( ) Yes / ( ) No

Able to work full day (8 hrs.)? ( ) Yes / ( ) No

If No, specify max hours/day: ____ hours

B. Strength Level:

( ) Sedentary (Up to 10 lbs. occasionally)

( ) Light (Up to 20 lbs. occasionally)

( ) Medium (Up to 50 lbs. occasionally)

( ) Heavy (Up to 100 lbs. occasionally)

( ) Very Heavy (Over 100 lbs. occasionally)

( ) No Strength Limitations

C. Physical Limitations:

Specify Restrictions: *(Use codes: O=Occasionally, F=Frequently, C=Constantly, N=None)*

Maximum Lifting: ____ lbs. @ ____ (Frequency: O/F/C/N)

Maximum Pulling: ____ lbs. @ ____ (Frequency: O/F/C/N)

Maximum Pushing: ____ lbs. @ ____ (Frequency: O/F/C/N)

D. Allowed Duration (hours per day): *(Use codes: O=Occasionally, F=Frequently, C=Constantly, N=None)*

Sitting: ____ hrs. / Standing: ____ hrs. / Walking: ____ hrs.

Bending/Stooping: ____ (O/F/C/N)

Twisting: ____ (O/F/C/N)

Reaching Above Shoulder: ____ (O/F/C/N)

Climbing/Kneeling/Squatting: ____ (O/F/C/N)

Other: _____ ____ (O/F/C/N)

E. Is transitional work assignment being offered? ( ) Yes / ( ) No

If Yes, date offered _____

Assignment details (location, hours, reporting instruction) _____

_____

_____

Workers' Comp Contact Name: _____

Date: _____

Contact Phone: _____

Contact Email: _____