

COGNITIVE ACTIVITIES



Employee Name:	Job Class:
Employee Department:	

The employee is able to work FULL DUTY YES can start on: _____

The employee CANNOT work in any capacity at this time Specify disability period for off work status.
 Start date: _____ End date: _____

The employee can work, but with restrictions YES
Use the space below to specify the restrictions and/or limitations as it relates to work

COGNITIVE ACTIVITIES	Able to perform (unrestricted)	Cannot perform	Can perform with restrictions (specify restrictions) Use extra paper if needed	TEMP	PERM
COMPREHENSION					
Follow and understand instructions received orally					
Follow and understand instructions received in writing					
Ability to maintain attention and concentration for necessary periods					
Ability to do work requiring set limits, standards, and tolerances					
SIMPLE AND REPETITIVE TASKS					
Follow set procedures or set sequences					
Organize own work					
Ask questions or request assistance when needed					
Ability to remember locations and work procedures					
Ability to obtain information and answer questions regarding Agency procedures or standards for immediate staff					
WORK PACE					
Deal with emergency and/or time sensitive situations					
Ability to work with tightly scheduled and hurried pace					
Ability to meet deadlines					
Long and/or irregular hours					
Ability to perform activities within a schedule					
Maintain regular, predictable, punctual attendance					
Ability to complete normal workday and/or work week and perform at a consistent pace					
COMPLEX AND VARIED TASKS					
Ability for precise attention to detail					
Ability to synthesize, coordinate, and analyze data					
Ability to perform jobs requiring precise attainment of set limits, standards, and tolerances					
Ability to divide attention between issues requiring multi-tasking					
Frequent use of judgment on routine matters					
Ability to work in situations requiring judgment and adaptation of procedures from one task to another					

COGNITIVE ACTIVITIES	Able to perform (unrestricted)	Cannot perform	Can perform with restrictions (specify restrictions)	TEMP	PERM
RELATING TO PEOPLE					
Ability to get along with coworkers and/or peers					
Ability to perform work activities requiring negotiation with, explaining, redirecting, or persuading					
Ability to respond appropriately to evaluation and/or criticism					
Ability to frequently work with others (coworkers, supervisors, managers, clients, outside professions, etc.)					
Ability to have face to face interactions with others (coworkers, supervisors, managers, clients, outside professions, etc.)					
Ability to perform under circumstances of emotional stress					
Ability to work with violent and/or assualtive customers/clients					
Ability to diffuse residual emotional effects when crisis and/or emergency is over					
INFLUENCING OTHERS					
Ability to convince or direct others					
Ability to understand the meaning of words and to use them appropriately and effectively					
Ability to interact appropriately with people					
DECISION MAKING					
Ability to recognize potential hazards and follow appropriate precautions					
Ability to understand and remember detailed instructions					
Ability to make independent decisions or judgments based on appropriate information					
Ability to set realistic goals or make plans independent of others					
DIRECTION, CONTROL, PLANNING					
Ability to set realistic goals or make plans independent of others					
Ability to negotiate with, instruct, train, or supervise people					
Ability to respond appropriately to changes in the work condition(s)					
Ability to work as a Lead person in the absence of a supervisor (has broad technical knowledge)					
Responsibility for results					
For the tasks that have a TEMPORARY (Temp) restriction noted, please specify the duration anticipated for these limitations: Start Date: _____ End Date: _____					
<i>Please comment if there any other pertinent information that would be helpful to consider during the interactive process?</i>					
Print Physician Name:			Date:		
Physician Signature:			Phone Number:		