

## Program Physical Demands Analysis

|                     |                          |                    |                        |
|---------------------|--------------------------|--------------------|------------------------|
| <b>Program</b>      | B897 Paralegal           | <b>Date</b>        | May 2022               |
| <b>Co-Ordinator</b> | Elizabeth Strutt-MacLeod | <b>Chairperson</b> | Stephanie DeFranceschi |

| STRENGTH                  |                  |                |                                     |                                     |                                     |                                     |                                     |
|---------------------------|------------------|----------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Physical Demands          | WEIGHT           |                | * FREQUENCY                         |                                     |                                     |                                     |                                     |
|                           | Maximum (in lbs) | Usual (in lbs) | Never                               | Seldom                              | Minor                               | Required                            | Major                               |
| Lifting                   | 10               | 5-10           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Carrying                  | 10               | 5-10           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Pushing                   | 10               | 5-10           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Pulling                   | 10               | 5-10           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Fine Finger Movements     |                  |                | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Handling                  |                  |                | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Gripping                  |                  |                | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Reaching (Above Shoulder) |                  |                | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Reaching (Below Shoulder) |                  |                | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Foot Action (1 Foot)      |                  |                | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Foot Action (2 Foot)      |                  |                | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Comments:                 |                  |                |                                     |                                     |                                     |                                     |                                     |
|                           |                  |                |                                     |                                     |                                     |                                     |                                     |

| MOBILITY         |                                     |                                     |                                     |                                     |                                     |
|------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Physical Demands | * FREQUENCY                         |                                     |                                     |                                     |                                     |
|                  | Never                               | Seldom                              | Minor                               | Required                            | Major                               |
| Throwing         | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Sitting          | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Standing         | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Walking          | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Running          | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Climbing         | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Bending/Stooping | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Crouching        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Kneeling         | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Crawling         | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Twisting         | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Balancing        | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Comments:        |                                     |                                     |                                     |                                     |                                     |
|                  |                                     |                                     |                                     |                                     |                                     |

| SENSORY / PERCEPTUAL   |                                     |                                     |                                     |                                     |                          |
|------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|
| Physical Demands       | * FREQUENCY                         |                                     |                                     |                                     |                          |
|                        | Never                               | Seldom                              | Minor                               | Required                            | Major                    |
| Hearing – Conversation | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Hearing – Other Sounds | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| Vision – Far           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| Vision – Near          | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Vision – Colour        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |
| Vision – Depth         | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| Perception – Spatial   | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Perception – Form      | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Feeling                | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> |
| Reading                | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Writing                | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Speech                 | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Comments:              |                                     |                                     |                                     |                                     |                          |
|                        |                                     |                                     |                                     |                                     |                          |

| WORK ENVIRONMENT       |                                     |                                     |                                     |                          |                                     |
|------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|-------------------------------------|
| Physical Demands       | * FREQUENCY                         |                                     |                                     |                          |                                     |
|                        | Never                               | Seldom                              | Minor                               | Required                 | Major                               |
| Inside Work            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Outside Work           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Hot/Cold               | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Humid/Dry              | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Dust                   | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Vapour Fumes           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Noise                  | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Moving Objects         | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            |
| Hazardous Machines     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Electrical             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Sharp Tools etc.       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Radiant/Thermal Energy | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Slippery               | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/>            |
| Congested Worksite     | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Comments:              |                                     |                                     |                                     |                          |                                     |
|                        |                                     |                                     |                                     |                          |                                     |

| CONDITIONS OF WORK            |                          |                          |                                     |                                     |                                     |
|-------------------------------|--------------------------|--------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Physical Demands              | * FREQUENCY              |                          |                                     |                                     |                                     |
|                               | Never                    | Seldom                   | Minor                               | Required                            | Major                               |
| Travelling                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Work Alone                    | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            |
| Work Independent but in group | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Deadline Pressures            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Interact with Public          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Operate Equipment/ Machinery  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Comments:                     |                          |                          |                                     |                                     |                                     |
|                               |                          |                          |                                     |                                     |                                     |

| Accessibility         |   |
|-----------------------|---|
| Wheelchair accessible | <input checked="" type="checkbox"/> yes <input type="checkbox"/> no |
| Comments:             |   |
|                       |   |

**\* Frequency:**  
 Never ..... Not performed.  
 Seldom ..... Seldom performed. Not daily.  
 Minor..... Minor daily activity. Less than 1 hour  
 Required ..... Frequent repetition, for 1-3 hours daily

Major.....Major job demand. Maximum ability required. Frequent repetition for more than 3 hours daily.