FORM 5: Sample Vocational Tool

Client Information Form

Contact Information

Name:
Phone:
SSN:

Employer/requirements

Your Employer:	Your Title:
Salary: $ Bonus: $ Years Employed? Last Day Worked? /	
Responsibilities/duties of your job: Average hours per day for each:	
1.	
2.	
3.	
4.	
5.	
How many hours a week do you work?	How many hours a week do you work outside the office?
Did you have supervisory duties?	How many employees did you supervise?
If your job requires travel, please describe:	
PHYSICAL RESPONSIBILITIES Please estimate the number of hours (or portion of an hour) for each applicable category	
Sitting: __most hours sitting at one time __total hours sitting in a day	
Standing: __most hours standing at one time __total hours standing in a day	
Walking: __most hours walking at one time __total hours walking in a day	
Computer use: __most hours of computer use at one time __total hours of computer use in a day	

Lifting (how much): __up to 10 lbs __up to 15 lbs __up to 20 lbs __20 – 30 lbs __30 – 50 lbs __over 50 lbs
Lifting (how often): __1-5% of the day __6-15% of the day __16-33% of the day __34-66% of the day __over 66%

This form originally appeared in *An Attorney's Guide to ERISA Disability Claims.*

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Reading: __1-5% of the day __6-15% of the day __16-33% of the day __34- 66% of the day __over 66%
Telephone: __1-5% of the day __6-15% of the day __16-33% of the day __34-66% of the day __over 66%
Please explain any other important physical/cognitive requirements of your job:
Anything else we should know about your job?

Employee Benefits

Do you have health coverage at work?_____If so, what is the name of the insurer:
Check the appropriate benefits:
__ Pension Plan __Profit Sharing Plan __401(k) __Stock Plan
If granted disability benefits, are you eligible for health coverage?
If granted disability benefits, are you eligible for pension benefits?
If granted disability benefits, are you eligible for waiver of life insurance premiums?
OTHER BENEFITS
Have you received severance benefits?
Have you applied for Social Security Disability Benefits?
Have you applied for Workers Compensation Benefits?

Disability/restrictions

Please describe your primary illness or disability:
Please describe any secondary illness or disability:

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Please list your symptoms (physical and/or cognitive) in order of importance starting with the most important:
1.
2.
3.
4
5.
6.
7.

How Your Symptoms Make You Disabled

Please describe how each one of your symptoms listed above affects your ability to do your job:
Symptom 1:
Symptom 2
Symptom 3
Symptom 4.
Symptom 5:
Symptom 6:
Symptom 7:

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