

LIST OF ESSENTIAL DUTIES

EMPLOYEE NAME: _____ HOSPITAL NAME: _____ DATE: _____

EMPLOYER REPRESENTATIVE: _____ PHONE NUMBER: _____

ESSENTIAL DUTIES OF JOB TITLE: _____

DUTY	IS EMPLOYEE ABLE TO PERFORM THIS DUTY:	
	YES	NO
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

SIGNATURE OF PHYSICIAN

DATE

PLEASE PRINT NAME OF PHYSICIAN

SPECIALTY

TELEPHONE NUMBER