



San Joaquin County
Human Resources Division
 44 N. San Joaquin Street, Suite 330
 Stockton, CA 95202 Tel: (209) 468-3370 Fax: (209) 953-7330

COGNITIVE ABILITIES FORM

Today's Date: _____

EMPLOYEE'S NAME _____
 Job Class: _____
 Condition: _____

Employee is able to work **FULL DUTY**: Yes or No
 if No, please indicate if employee is able to work with restrictions: Yes or No
if Yes, please use the space below to specify the employee's capability for each task.
 if No, please specify the period of time that the employee will be **OFF WORK**:

_____ thru _____
 (start date) (end date)

Nature of restrictions: **TEMPORARY** or **PERMANENT**

Re-evaluation Date: _____

**On a scale of 1 to 10, please advise on the employee's ability to perform each task.
 10 being the most capable (no limitations)**

COGNITIVE ABILITY	1	2	3	4	5	6	7	8	9	10	Comments:
Follow verbal & written instructions											
Maintain established work pace											
Comply with established work & safety procedures											
Respond appropriately to changes in the work setting											
Perform simple tasks											
Perform complex & varied tasks											
Organize tasks & set priorities											
Manage multiple tasks at the same time											
Work cooperatively with others											
Interact with customers/public											
Give training & instructions											
Direct or supervise others											
Use basic problem solving tech.											
Work autonomously or with minimal supervision											
Make independent decisions based on data or circumstance											
Perform tasks requiring short and/or long term memory											

Any recommended assistive devices? _____
 Any medication effects that may impair the employee at work? _____
 Other limitations to consider: _____

Note to Physician: *By signing this form you confirm that a job analysis was provided to you and you have reviewed the data contained in the report and understand the essential functions required for the employee's position.*

 (physician name--please print) (physician signature) (date)