EMPLOYEE LIGHT DUTY WORK REQUEST AND LIMITATION FORM

To: Installation Head: _____ Date: _____

Employee's Name: _____ Signature: _____

Employee's EIN: _____ USPS Work Location: _____

I am requesting temporary assignment to light duty work. Following is a medical statement from my licensed physician stating, when possible, the anticipated duration of the convalescence period and/or limitations.

Please indicate below the patient's ability to perform the following tasks when applicable:

ACTIVITY	CONTINUOUS	INTERMITTENT	#HRS/Day
1. Lifting/ Carrying: (State Max. Weight)	#Lbs.	#Lbs.	
2. Sitting			
3. Standing			
4. Walking			
5. Climbing			
6. Kneeling			
7. Bending/Stooping			
8. Twisting			
9. Pulling/Pushing			
10. Simple Grasping			
11. Fine Manipulation (includes keyboarding)			
12. Reaching above Shoulder			
13. Driving a Vehicle (Specify) -			
14. 0perating Machinery (Specify)_			
15. Temperature Extremes			
16. High Humidity			
17. Chemical, Solvents, etc. (Identify)			
18. Fumes/Dust (Identify type)			
19. Noise (Give dBA)			
20. Other: (Describe)			

Other medical limitations and/or special instructions: _____

_____

Anticipated duration of convalescence period: _____

____ May work Full-time

____ May work Part-time for _____ hours per day

Attach additional medical information you feel might be helpful in assigning this employee to appropriate duties.

_____ _____ _____

(Physician's Signature) (Printed Name) (Date)

_____ _____ _____

(Address) (City, State, Zip Code) (Phone)