UNITED STATES POSTAL SERVICE

REQUEST FOR TEMPORARY LIGHT DUTY ASSIGNMENT

To: Installation Head

Employee Name (printed)	EID	Pay Location

I am requesting a temporary light duty assignment/re-assignment for a period of approximately _____ days under Article 13 of the National Agreement. I have attached a medical statement from a licensed physician or a written statement from a licensed chiropractor in support of this request: Yes _____ No _____

NOTE TO EMPLOYEE: No action can be taken on this request until you submit an appropriate medical statement indicating work limitations and the approximate duration of the limitations.

I understand that it is my responsibility to provide medical information updates indicating the nature of my illness or injury and prognosis for recovery to my official superior while on a temporary light duty assignment.

I understand that every effort will be made to assign work within my present craft or occupation group. I further understand that after all efforts are exhausted, consideration will be given to re-assignment to another craft or occupation group within the same installation.

Employee's Signature	Date

Supervisor Name (printed)

Supervisor's Signature	Date and Time

REQUEST FOR TEMPORARY LIGHT DUTY

PART A - (To be completed by employee and given to immediate supervisor)

I am requesting a temporary light duty assignment to accommodate a non-work related injury or illness, and I have attached appropriate medical documentation to support my request. I understand -light duty is not a "make work" situation, it is an accommodation. I understand I may be required to have my work hours changed in order to provide me with work. All efforts will be made to provide work within my craft and salary level that meets my restrictions.

Employee's Printed Name	Signature/Date
Social Security Number	Position
Office/Tour	Duty Hours/NS Days
Phone Number	HMO Number (if applicable)
Physician's Name	Physician's Specialty
Physician's Address	Physician's Telephone Number
City and State	

PART B - (To be completed by employees immediate supervisor and submitted to the Postmaster/Plant Manager, or Designee)

Based on the medical restrictions outlined on the accompanying Physician or Practitioner's Certification (4F HR-002):

_____Work **IS** Available In My Unit

_____Work **IS NOT** Available In My Unit

Supervisor's Signature	Date
Concurrence of Higher Level Manager	Date

REQUEST FOR TEMPORARY LIGHT DUTY

PART C - (To be completed by Postmaster/ Plant Manager, or Designee)

_____Light Duty is approved from_____ to _____. If Light Duty is required beyond 90 days, Medical Unit concurrence is required. *See Part D.*

_____Light Duty is denied. (Provide employee with a written notice as to the reason(s) for denial of Light Duty work.)

_____ _____

Signature/ Concurrence (Postmaster /Plant Manager/ Designee) Date

_____

Printed Name (Postmaster /Plant Manager/ Designee)

NOTE: ASSOCIATE OFFICE POSTMASTERS, FORWARD A COPY OF THIS COMPLETED FORM TO YOUR MPOO.

PART D - (To be completed by USPS District Medical Officer)

IF APPROVAL OF LIGHT DUTY IS FOR **90 DAYS OR MORE**

_____ _____

Signature/ Concurrence of USPS District Medical Officer Date

PRIVACY ACT STATEMENT: "The collection of this information is authorized by 39 U.S.C. 401 and 1001. This information will be used to make a determination concerning your request for light duty or return to duty after surgery/ illness / injury. As a routine use, this information may be disclosed to an appropriate government agency, domestic or foreign, for law enforcement purposes; where pertinent, in a legal proceeding to which the USPS is a party or has an interest; to a government agency in order to obtain information relevant to a USPS decision concerning employment, security, clearances, contracts, licenses, grants, permits or other benefits; to a government agency upon its request when relevant to its decision concerning employment, security clearances, security or suitability investigations, contracts, licenses, grants or other benefits; to a congressional office at your request; to an expert, consultant, or other person under contract with the USPS to fulfill an agency function; to the Federal Records Center for storage; to the Office of Management and Budget for review of private relief legislation; to an independent certified public accountant during an official audit of USPS finances; to an investigator, administrative judge or complaints examiner appointed by the Equal Employment Opportunity Commission for investigation of a formal EEO complaint under 29 CFR 1614; to the Merit Systems Protection Board or Office of Special Counsel for proceedings or investigations involving personnel practices and other matters within their jurisdiction; to a labor organization as required by the National Labor Relations Act; to the Office of Personnel Management in making determination related to veterans preference, disability retirement and benefit entitlement; to officials of the Office of Worker's Compensation Programs, Retired Military Pay Centers, Veterans Administration, and Social Security Administration in the administration of benefit programs; to an employee's private treating physician and to medical personnel retained by the USPS to provide medical services in connection with an employee's health or physical condition related to employment; and to the Occupational Safety and Health Administration and the National Institute of Occupational Safety and Health when needed by that organization to perform its duties under 29 CFR Part 19. Completion of this form is voluntary; however, failure to provide information may result in disapproval of your request."

The above statements are consistent with the current description of 120-090, the Privacy Act system covering these records. Information collected must be maintained and used in accordance with Privacy Act regulations (ASM 353) and USPS 120-090.

PHYSICIAN OR PRACTITIONER CERTIFICATION

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

_____ _____

Patient's Name (PRINTED) Patient's SSN or Medical #

What is the cause of the employee's need for a restricted work assignment, and what parts of the body are affected? (DO NOT INCLUDE DETAILED MEDICAL INFORMATION)

_____

_____

Estimate duration for restriction(s). Give specific date, if known:_____

What was the last date you examined the employee?_____

Please indicate below the patient's ability to perform the following tasks continuously or intermittently, and give the number of hours per day they may perform each task:

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)			
21. Are interpersonal relations affected because of a neuropsychiatric condition? (e.g., Ability to give or take supervision, meet deadlines, etc.) _____Yes _____No (Describe)_____ _____ _____			

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

_____ _____ _____ _____

Doctor Signature Doctor's Name (PRINTED) Specialty Date

_____

Address City and Zip Code Phone