REQUEST FOR TEMPORARY LIGHT DUTY

To: Senior Plant Manager
Attn.: Manager, Safety & Health Services
San Antonio, TX 78284-9441

In accordance with Article 13 of the National Agreement, I request your approval for light duty due to an off the job injury/illness which precludes me from performing my full duties. My doctor's certification supporting this request is attached and it identifies the time frame such light duty is requested for and states the specific physical limitations/work restrictions which should apply.

I voluntarily agree to accept any light duty assignment offered. I fully understand that any light duty assignment is offered or is available, it will be my new assignment. And it will be offered in accordance with Article 13 of the National Agreement and to meet my medical restrictions. The light duty offer is defined by its own terms without any reference to any previous assignment, which I may have held. I also understand that this new assignment, if available/offered, may be necessarily different from my regular assignment and may entail work hours different from my former regular hours of work. I acknowledge that the light duty assignment, if available, will be reviewed when my current medical information expires and that any assignment may be modified or eliminated when my medical restrictions change or to meet the needs of the service.

(check one) ___ Full Time Reg. ___ Part Time Reg. ___ Part Time Flex.

(Printed Name)	(Current Bid Position)	(Bid Pay Location)	(Current Work Area)
(Social Security Number)	(Schedule Days Off)	(Duty Hours)	(Home Phone)

(Signature) (Date)

To be completed by USPS Medical Officer

_____ Concur with attached medical certificate.

_____ Non Concur with attached medical certificate.

1. Light Duty is permissible : FROM: _____ TO: _____
2. Your work restrictions during this light duty period are: _____

(Medical Officer's Signature) (Date)

REQUEST FOR TEMPORARY LIGHT DUTY

To be completed by reviewing official.

To: _____

_____ Your request for light duty has been approved as follows:

1. Your period of light duty is FROM: _____ TO: _____

a. Your light duty work week and duty hours are: _____
b. Your duty location(s) will be: _____
c. Your work restrictions will be as indicated above and/or attached.

2. Be aware that your duty hours and workweek schedule while in a light duty status may be changed to meet the needs of the service.

3. **There is no guarantee that 40 hours of light duty work will be available.**

4. **Overtime is not Authorized during periods of light duty.**

NOTICE: At least three working days prior to the expiration of this light duty authorization you are required to provide the Medical Unit either medical approval for your return to full duty, or medical certification with a new request for an additional period of light duty. The certification would be obtained off the clock, i.e., sick or annual leave or LWOP. Your failure to comply with the three-day response may result in a delay of your return to either full or additional light duty. **Under no circumstances are you to clock in without an up-dated request for light duty and/or revised medical information after your light duty request has expired.**

(Each case will be reviewed on an individual bases due to medical restrictions and work available, otherwise the employee would have to elect to take sick leave, annual leave, or LWOP.)

Approved By: _____ _____ _____
(Signature) (Position) (Date)

_____ Your request for temporary light duty has been denied. The reason(s) follow:

_____

_____

_____

Disapproved By: _____ _____ _____
(Signature) (Position) (Date)

UNITED STATES
POSTAL SERVICE

RIO GRANDE PERFORMANCE CLUSTER - RETURN TO WORK MEDICAL CLEARANCE CERTIFICATION

In accordance with ELM 865.1 - return to work clearance may be required for absences due to an illness, injury, outpatient medical procedure (surgical) or hospitalization when management has a reasonable belief that the employee may not be able to perform the essential function of their position and/or the employee may pose a direct threat to the health or safety of self or others due to that medical condition.

Employee Name: _____ SSN# _____ Craft: _____
Home Address: _____ Home/Cell Phone: _____
Facility Assigned: _____ Supervisor: _____ P/L: _____
Work Phone #: _____ Work Fax #: _____

ATTENDING PHYSICIAN COMPLETE BELOW

ICD-9 CODE(S) for this absence: _____ CPT CODE(S): _____

PERIOD EMPLOYEE WAS UNABLE TO WORK FOR THIS ABSENCE: FROM: _____ TO: _____

DATE EMPLOYEE MAY RETURN TO REGULAR WORK WITH NO RESTRICTIONS: _____

To be completed only If work restrictions are required (a period of light duty)

TIME PERIOD WORK RESTRICTIONS ARE REQUIRED: FROM: _____ TO: _____

Please provide specific restrictions. Example: Lifting / carrying: "Up to 10 lbs frequently and 30 lbs occasionally", and Standing / walking: "Up to 4 hrs/day, up to 1 hr continuously" If restrictions are not needed for any activity, please note with N/A after the activity

RESTRICTIONS:
Maximum work hours per day: _____ Working under medication effects (hrs/day): _____

Can the employee work overtime? Yes ☐ No ☐

Lifting / Carrying (lbs & hrs/day): _____

Pushing / Pulling / Twisting (lbs & hrs/day): _____

Standing / Walking / Climbing (hrs/day): _____

Stooping / Bending (hrs/day): _____

Sitting / Squatting / Kneeling (hrs/day): _____

Reaching/working above shoulder height (hrs/day): _____ Grasping / Fine manipulation (hrs/day): _____

Operating motor vehicles (hrs/day): _____ Working at heights or in a mechanized environment (hrs/day) _____

Other restrictions/Comments: _____

_____ _____ _____
PRINTED NAME OF ATTENDING PHYSICIAN | SIGNATURE OF ATTENDING PHYSICIAN | DATE SIGNED

TELEPHONE NUMBER _____ FAX NUMBER: _____

To be completed below by Postal Service medical providers, NOT attending physicians

I CONCUR: _____ I DO NOT CONCUR: _____ RECOMMENDATIONS / COMMENTS: _____

_____ _____ _____
POSTAL PROVIDER'S SIGNATURE | POSTAL PROVIDER'S NAME – PRINTED | DATE SIGNED

PLEASE SEND TO: RIO GRANDE PERFORMANCE CLUSTER
MEDICAL ADMINISTRATION
1 POST OFFICE DRIVE, SAN ANTONIO, TX 78284-9442
FAX: 210-368-8397

RTW 6/30/05

RETURN-TO-WORK CLEARANCE REFERENCES

ELM 864.4

864.41

Employees returning to duty after 21 days or more of absence due to illness or serious injury require medical certification. Employees must submit medical evidence of their ability to return to work, with or without limitation. A medical officer, contract physician, or Occupational Health Nurse Administrator (delegated by the Associate Area Medical Director) evaluates the medical report and makes a medical assessment to assist management in employee placement to jobs where they can perform effectively and safely.

864.42

In cases of occupational illness or injury, the employee will be returned to work upon certification from the treating physician, and the medical report will be reviewed by an Injury Compensation Specialist as soon as possible thereafter.

EL 311

342 Return to Duty after Extended Illness or Injury

342.1 **Certification After 21 Days.** Employees returning to duty after 21 days or more of absence due to illness or serious injury must submit medical evidence to their ability to return to work with or without limitations. A medical officer, contract physician, or Occupational Health Nurse Administrator evaluates the medical report and, when required, assists in employee placement to jobs where they can perform effectively.

342.2 **Other Required Certification.** Employees returning to duty after an absence for communicable or contagious diseases, as well as mental and nervous conditions, diabetes, cardiovascular diseases, epilepsy, or following hospitalization, must submit a physician's statement stating unequivocally that they are fit for full duties without hazard to themselves or others, or indicating the duties which they are capable of performing. These also must be approved by the postal medical officer, contract clinic, or Occupational Health Nurse Administrator where available. In facilities where there is no medical officer, the opinion of a postal medical officer designated by the Region must be requested in questionable cases.

342.3 **Contents of Certification.** All medical certifications must be detailed medical reports, and not simply a statement of ability to return to work. There must be sufficient data to make a determination that the employee can return to work without hazard to self or others. In instances of hospitalization for mental or nervous conditions, the attending physician's certificate must also state that the employee has been officially discharged from the hospital. In diabetes and epilepsy cases, the certificate must state that the condition is under adequate control (see guidelines). The medical officer, if available, makes the final medical determination of suitability for return to duty and/or the need for limited duty assignment. Other offices must refer the case to the medical officer designated by the Region.

PUB 71, June 97 FMLA

V1. Return to Duty

At the end of FMLA leave, the employee will be returned to the same position held when the absence began (or to an equivalent position), provided the employee is able to perform the functions of the position, and would have held that position at the time the employee returns, if time off had not been taken. In order to return to duty, if the absence was because of a personal health condition and exceeds 21 calendar days, or is because of exposure to a communicable or contagious disease, mental or nervous condition, diabetes, cardiovascular disease, epilepsy, or a condition involving hospitalization, the employee must submit medical evidence of the ability to return to work before returning to work. The employee must submit medical certification stating that he/she is capable of performing the job. The medical certification must contain detailed reports with sufficient data to make a determination that the employee can return to work without hazard to self or others. A postal medical officer, contract physician, or Occupational Health Nurse Administrator evaluates the medical report and makes the final determination of suitability for return to duty.