UNITED STATES POSTAL SERVICE

LIGHT DUTY REQUEST/APPROVAL FORM

(For off-the-job injuries and illnesses when job modifications are indicated.)

Privacy Act Statement: The collection of this information is authorized by 39 U.S.C. 401 and 1001. This information is used to enable supervisors to schedule employees within their work restrictions. As a routine use, the 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 Personnel 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 an 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 and to a labor organization as required by the National Labor Relations Act. Completion of this form is voluntary; however, if the information is not provided, postal management may be unable to schedule appropriate work assignments.

Employee Name: _____ **EIN:** _____

Supervisor: _____ **Position:** _____

Tour: _____ **Office:** _____ **Pay Loc:** _____

I, _____**, am voluntarily requesting**

☐ **a temporary light duty assignment**
☐ **an extension of my original light duty request from** _____ **(date)**
☐ **a permanent light duty assignment**

_____ _____
Employee Signature **Date**

Supervisor/Management Approval

Yes _____**Temporary** _____ **Permanent light duty is available within the restrictions set forth by the attending physician. I must show the greatest consideration for the full-time regular or part-time flexible employees, giving each request for light duty careful attention per Article 13.2.C. Every effort shall be made to reassign the concerned employee within the employee's present craft or occupational group, per Article 13.4.A.**
No _____**Temporary** _____ **Permanent light duty is not available within the restrictions set forth by the attending physician. I must notify the employee in writing of the decision to deny the temporary light duty request, stating the reasons for the inability to reassign the employee per Article 13.**
Temporary or Permanent (circle one) light duty assignment to consist of the following duties:

_____

_____

_____

Hours _____ **Work Schedule** _____

Tour _____ **Pay Location** _____ **Supervisor** _____

Light Duty Assignment approved through _____ **(Date)**

_____ _____
Manager Signature Date

Attachment 1

UNITED STATES POSTAL SERVICE

Physician or Practitioner Certification

Patient's Name _____

Date of Birth _____

What is the cause for a restricted work assignment and what parts of the body are affected?

_____

What is the duration of the restrictions? _____

Activity	Continuous	Intermittent	Hrs/Day
Lifting/carrying: (max weight)			
Sitting			
Standing			
Walking			
Climbing			
Kneeling			
Bending/stooping			
Twisting			
Pushing/pulling			
Simple grasping			
Fine manipulation (including keyboarding)			
Reaching above shoulder			
Driving a vehicle			
Operating machinery			
Temperature extremes			
High humidity			
Chemical solvents etc. (identify)			
Fumes/dust (identify)			
Noise			
Other (describe)			

Are interpersonal relations affected because of a neuropsychiatric condition?
(Ability to give or take supervision, meet deadlines etc.) _____ Yes _____ No

If so, describe _____

Physician Signature Physician Printed Name Date

_____

Address Phone

_____

Attachment 2