EMPLOYEE LIGHT DUTY
WORK REQUEST AND LIMITATION FORM

TO: Postmaster _____ DATE_____

NAME_____
Last First Middle

WORK LOCATION_____

As per Article 13, Section 2A of the National Agreement, I am requesting temporary assignment to light duty work. Following is a medical statement from my licensed physician or written statement from my licensed chiropractor stating, when possible, the anticipated duration of the convalescence period and/or limitations.

LIMITATIONS

_____Limited use of_____Right Arm_____Left Arm
_____No use of_____Right Arm_____Left Arm
_____Limited use of_____Right Hand_____Left Hand
_____No use of_____Right Hand_____Left Hand
_____Limited Bending/Stooping
_____No Bending/Stooping
_____Limited Walking for_____hours per day
_____Limited Sitting for_____hours per day
_____No Steps/Ladder climbing
_____No Pushing/Pulling over_____pounds
_____No Lifting over_____pounds
_____No Vehicle driving
_____Limited Vehicle Driving for_____hours per day
_____Avoid work requiring good depth perception or near point vision

Other medical limitations and/or special instructions

_____

_____

_____

_____

_____

Anticipated duration of convalescence period _____

_____May work Full-time
_____May work Part-time for_____hours per day

Physician's Signature_____Date_____