ALBUQUERQUE PUBLIC SCHOOLS

Human Resources – Extended Leaves Office

Student Transportation Services
MEDICAL RELEASE

Employee Name: ______________________ Employee Number ____________ Employee's Signature ____________________

Employees are required to reinstate with the Extended Leaves Office prior to returning to the work site. Return this original Medical Release form to the Extended Leaves/Sick Leave Bank Office, Alice and Bruce King Educational Complex, East Tower, Suite 210.

TO BE COMPLETED BY EMPLOYEE'S HEALTH CARE PROVIDER

The employee must provide safe and reliable transportation service by operating various school buses in transporting passengers to and from school as well as related activities. To identify and communicate mechanical/maintenance and/or emergency situations to Route Operations. Assure a safe, on-time service and customer satisfaction and maintain the highest level of ethical behavior with our customers, fellow employees, and community we serve.

PHYSICAL DEMANDS: The physical demands described here are representative of those that must be met by the incumbent to successfully perform the essential functions of the job with or without reasonable accommodation:

- The employee must be able to drive a motor vehicle.
- The employee must regularly lift and move up to 75 pounds in equipment and supplies which requires bending, stooping and lifting.
- The employee must be able to climb ladders and perform the essential functions at elevated levels.
- The employee must use hands and arms to manipulate objects.
- The employee must use keyboards, tools and other controls.
- The employee must sit and stand for long periods of time.
- The employee must have normal vision and hearing with or without aid.
- The employee must be able to move about assigned location unaided during the day.
- The employee must wear protective clothing as requested or assigned.

I have reviewed the physical demands of a Bus Driver as listed above. Any restrictions that the employee must comply with and the duration of such restrictions are indicated below:

Restriction ______________________________ Duration ____________________

______________________________ ____________________

Employee can return to work on: ________/________/________

______________________________ Health Care Provider's Signature ____________ Date

______________________________ Health Care Provider's Address ____________ Phone Number

IF YOU HAVE RESTRICTIONS, YOUR SUPERVISOR MUST SIGN BELOW: ☐ I am willing: ☐ I am not willing: to work with the above restrictions for this duration.

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Supervisor's Signature