



**ALBUQUERQUE PUBLIC SCHOOLS**  
Human Resources – Extended Leaves Office

# Police Department 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**

**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 occasionally lift and move up to 50 pounds in supplies which requires bending, stooping and lifting.
- The employee must be physically able to intervene in student confrontations following established procedures.
- The employee must apply unarmed defensive attics techniques on subjects and/or multiple subjects.
- 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 be able to diffuse student confrontations verbally and physically.
- The employee must have the physical fitness to move about the campus freely.
- The employee must be able to climb ladders and perform the essential functions of the job at elevated levels.

I have reviewed the physical demands of a Police Department Officer. 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.

\_\_\_\_\_  
Supervisor's Signature