ALBUQUERQUE PUBLIC SCHOOLS

HUMAN RESOURCES

Clerical/Secretarial: Work Restriction Duration/Clearance

PART I: TO BE COMPLETED BY EMPLOYEE	
Employee Name: **Employee Number:** ☐☐☐☐☐☐	**Type of Leave:** **MEDICAL**
Employee's Position:	
Beginning Date of Leave: ____/____/____	**Date Restriction Began: ____/____/____**
Employee Signature:	**Date:**
PART II: TO BE COMPLETED BY EMPLOYEE'S HEALTHCARE 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 25 pounds in supplies which requires bending, stooping and lifting.
- 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.

I have reviewed the physical demands of a clerk/secretary 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 _____/_____/_____.

Healthcare Provider's Signature:	**Date:**
Healthcare Provider's address and telephone Number:	

Please return original form to: Extended Leaves Office, City Center, Suite 210 East.

If you have been on an extended leave of absence you will be required to reinstate with the Extended Leaves Office prior to returning to work site.

If you have restrictions please have supervisor sign below.

I am willing_____ I am not willing_____ to work with the above restrictions

_____

Signature **Phone #** **Extension**