Hillsboro School District 1J - EMPLOYEE MEDICAL LEAVE

Obtain the HR108 or HR109 from HR, your office manager, supervisor, or the online document management system.

CHECKLIST

Do **NOT** give the entire leave packet to your health care provider. **Separate** the forms as listed below to use at the appropriate time. **Submit** forms directly to the Benefits Office. (Note: some pages are yours to keep-marked at top left)

_____**1.** **Read the Detailed Leave Instructions** – on the following pages (keep pages 1 through 4 for your information only)

_____**2.** **Request for Medical Leave (page 5)**

Due: At least 30 days in advance or immediately
Do **NOT** wait to submit your request until you have medical certification.
NOTE: Transportation employees complete HR109
Obtain Supervisor/Admin signature and forward to the Benefits Office.
MAKE SURE TO CHECK WHAT ACCRUED LEAVE(S) YOU WANT TO USE ON THE HR LEAVE FORM: SICK LEAVE; PERSONAL LEAVE; VACATION (if applicable)

_____**3.** **Employee Medical Certification or equivalent (page 6 & 7)**

Planned absence: This is due before starting your leave.
Unplanned absence: This is due with 15 days of first missing work.
Send/fax this directly to the Benefits Office for medical confidentiality.
Make sure to complete your provider's release of information

_____**4.** **Return to Work Recommendation, Fitness-for-Duty or equivalent (page 8-10)**

Due: Two business days prior to returning
Send/fax this directly to the Benefits Office for medical confidentiality.
Agility Transportation Assistant – Agility Bus Driver

_____**5.** **Report your absences using your available paid leave - Frontline**

You must use your available sick leave, then vacation if applicable, prior to taking unpaid leave.

_____**6.** **Links to the Short Term Disability**

https://www.standard.com/mybenefits/oebb/claim_forms.html

https://americanfidelity.com/claims

Leave Related Contacts and Resources

Benefits Office: Phone: 503-844-1518 Confidential fax: 503-844-1710

Email: hsdbenefits@hsd.k12.or.us Website: https://www.hsd.k12.or.us/Staff/Resources

Absence Reporting: Frontline Absence Management (Aesop)

Address: 3083 NE 49th Pl, Hillsboro, OR 97124

Hillsboro School District 1J

MEDICAL LEAVE INSTRUCTIONS

Submit all documents to the Benefits Office:

Confidential Fax: 503-844-1710 **Phone: 503-844-1518** **Email: hsdbenefits@hsd.k12.or.us**

DOCUMENTS: The ***Medical Leave Packet*** contains the necessary forms. Send all documents to the Benefits Office.

REQUEST LEAVE: Complete the ***Request for Medical Leave*** form as soon as your need for leave is known, with 30 days prior notice when possible.

MEDICAL CERTIFICATION: You may use the ***Family Member Medical Certification*** form that is in the leave packet. You will need to complete the first part of the form and then have the physician complete the medical section. Release of information forms: MODA and Kaiser have release of information forms that must be completed and given to the physician along with the medical certification. Send medical certification directly to the Benefits Office for medical confidentiality. This is due prior to your leave beginning or within 15 days that your need for leave becomes known. If there are extenuating circumstances that will not allow you to meet this deadline, please advise the Benefits Office. Failure to provide a complete and sufficient medical certification in a timely manner may result in a denial of your FMLA and/or OFLA request, may be subject to the District's attendance policy under the Code of Conduct and may result in separation.

REPORTING YOUR ABSENCES: You are required to follow normal absence reporting procedures, including Frontline Absence Management (Aesop), if applicable. If you are uncertain of your reporting responsibilities, please contact your Administrator/Supervisor or the school/department secretary.

REQUESTING LEAVE EXTENSIONS: If you wish to extend your leave, please submit an email request to HR Director and the Benefits Office at least 30 days prior to the end of your approved leave.

Additional Unpaid Leave: A request to take additional unpaid leave, beyond your FMLA and/or OFLA entitlement, requires the approval of the HR Director for your work group. Please submit your email request to them as soon as possible. This will allow appropriate staffing arrangements to be made.

INTERMITTENT LEAVE: In addition to your normal absence reporting procedures:

Scheduled absences: You must advise your Administrator that it is part of your FMLA/OFLA leave and provide your Administrator with as much notice as possible. It is expected that you will schedule, to the best of your ability, leave- related appointments during your time off.

Unexpected absences: You must also inform your Administrator at the time of your absence, or within 24 hours of your return, that the absence is part of your FMLA or OFLA intermittent leave. Failure to do this will cause the absence to not maintain protected status. Follow normal absence reporting procedures.

Intermittent leave is to be used for qualifying medical related reasons, in accordance with the physician's certification.

Changes to your leave: If the frequency or duration of your need to care for yourself or your family member changes, you will need to provide updated medical certification stating the medical reason for the change. **Bus Driver & Transportation Assistant: HR109 must be completed for each absence, signed by your administrator / supervisor and sent to the Benefits Office within 3 days of your return to work.**

RETURN TO WORK: Following a surgery or absence of five or more days. This is due at least two business days prior to your return. Your return will be delayed until a medical release is provided. Please provide your medical release to the Benefits Office for approval at FAX: 503-844-1710. Work restrictions: A full medical release is generally required for your safety. Any restrictions or requests for work accommodations must be specific and the duration of the limitations indicated on your release. It may be necessary for you to provide additional medical information if the information provided is incomplete or there are concerns about your ability to safely perform your job.

A ***Return to Work Recommendation*** form is available in the Medical Leave Packet. Please provide your physician with your job description. **Bus Drivers & Transportation Assistants** need to have the Agility tests – schedule with supervisor.

USE OF PAID LEAVE: The District requires you to use your available paid leave in the order of accumulated sick leave and vacation if applicable. Once all paid leave is exhausted your leave will be unpaid.

BENEFITS WHILE ON LEAVE: Your District-paid benefits will continue if you are on a paid status (i.e. sick leave) or on approved leave under FMLA/OFLA. If no paid leave is used, your monthly out-of-pocket costs must be pre-paid before taking leave.

OTHER: Licensed employees**:** You are required to maintain licensure under TSPC while on leave. Failure to maintain an active TSPC license during your leave may impact your employment or paid status, if applicable.

CDL employees: You are required to maintain CDL licensure while on leave. Failure to maintain an active CDL license during your leave may impact your employment or paid status, if applicable.

Bus Drivers & Transportation Assistants: Will be required to have an Agility test before returning to work. Bus Drivers – Transportation Assistants.

B U R E A U   O F   L A B O R   A N D   I N D U S T R I E S

Val Hoyle, Commissioner

Oregon FAMILY LEAVE ACT

NOTICE TO EMPLOYERS AND EMPLOYEES

The Oregon Family Leave Act (OFLA) requires employers of 25 or more employees to provide eligible workers with protected leave to care for themselves or family members in cases of death, illness, injury, childbirth, adoption and foster placement. ORS 659A.150 - 659A.186

When can an employee take family leave?

Employees can take family leave for the following reasons:

- **Parental Leave** during the year following the birth of a child or adoption or foster placement of a child under 18, or a child 18 or older if incapable of self-care because of a mental or physical disability. Parental leave includes leave to effectuate the legal process required for foster placement or adoption.
- **Serious health condition leave** for the employee's own serious health condition, or to care for a spouse, same-gender domestic partner, custodial parent, non-custodial parent, adoptive parent, foster parent, biological parent, step parent, parent in law, parent of same-gender domestic partner, grandparent, grandchild, a person whom the employee is or was a relationship of in loco parentis, biological, adopted, foster or step child of an employee or the child of an employee's same-gender domestic partner.
- **Pregnancy disability leave** (a form of serious health condition leave) taken by a female employee for an incapacity related to pregnancy or childbirth, occurring before or after the birth of the child, or for prenatal care.
- **Sick child leave** taken to care for an employee's child with an illness or injury that requires home care but is not a serious health condition.
- **Bereavement leave** to deal with the death of a family member.
- **Oregon Military Family Leave** is taken by the spouse or same gender domestic partner of a service member who has been called to active duty or notified of an impending call to active duty or is on leave from active duty during a period of military conflict.

Who is eligible?

To be eligible for leave, workers must be employed for the 180 day calendar period immediately preceding the leave and have worked at least an average of 25 hours per week during the 180-day period.
Exception 1: For parental leave, workers are eligible after being employed for 180 calendar days, without regard to the number of hours worked.
Exception 2: For Oregon Military Family Leave, workers are eligible if they have worked at least an average of 20 hours per week, without regard to the duration of employment.
Exception 3: For compensable Workers Compensation injuries, for certain Workers Compensation injuries involving denied and then accepted claims and for certain accepted claims involving more than one employer.
Exception 4: When an employee is caring for a family member with a serious health condition and the same family member dies, the employee need not requalify with the 25 hour per week average to be eligible for bereavement leave

How much leave can an employee take?

- Employees are generally entitled to a maximum of 12 weeks of family leave within the employer's 12-month leave year.
- A woman using pregnancy disability leave is entitled to 12 additional weeks of leave in the same leave year for any qualifying OFLA purpose.
- A man or woman using a full 12 weeks of parental leave is entitled to take up to 12 additional weeks for the purpose of sick child leave.
- Employees are entitled to 2 weeks of bereavement leave to be taken within 60 days of the notice of the death of a covered family member.
- A spouse or same gender domestic partner of a service member is entitled to a total of 14 days of leave per deployment after the military spouse has been notified of an impending call or order to active duty and before deployment and when the military spouse is on leave from deployment.

What notice is required?

Employees may be required to give 30 days notice in advance of leave, unless the leave is taken for an emergency.
Employers may require that notice is given in writing. In an emergency, employees must give verbal notice within 24 hours of starting a leave.

Is family leave paid or unpaid?

- Although Family Leave is unpaid, employees are entitled to use any accrued paid vacation, sick or other paid leave.
- Employees are entitled to group health insurance benefits during family leave as if they continued working.

How is an employee's job protected?

Employers must return employees to their former jobs or to equivalent jobs if the former position no longer exists. However, employees on OFLA leave are still subject to nondiscriminatory employment actions such as layoff or discipline that would have been taken without regard to the employee's leave.

FOR ADDITIONAL INFORMATION:

Employer Assistance....... 971-673-0824
Portland........................... 971-673-0761
Eugene............................ 541-686-7623
Salem.............................. 503-378-3292
www.oregon.gov/BOLI

BOLI
Civil Rights Division
800 NE Oregon, #1045
Portland, OR 97232

January 2019

This is a summary of laws relating to Oregon Family Leave Act. It is not a complete text of the law.

Employees who have been denied available leave, disciplined or retaliated against for requesting or taking leave, or have been denied reinstatement to the same or equivalent position when they returned from leave, may file a complaint with BOLI's Civil Rights Division.

THIS INFORMATION MUST BE POSTED IN A CONSPICUOUS LOCATION

Workplace Accommodations Notice

Hillsboro School District is an equal opportunity employer and does not discriminate on the basis of race, religion, color, sex, age, national origin, disability, veteran status, sexual orientation, gender identity, gender expression or any other classification protected by law.

Hillsboro School District will make reasonable accommodations for known physical or mental disabilities of an applicant or employee as well as known limitations related to pregnancy, childbirth or a related medical condition, such as lactation, unless the accommodation would cause an undue hardship. Among other possibilities, reasonable accommodations could include:

- Acquisition or modification of equipment or devices;
- More frequent or longer break periods or periodic rest;
- Assistance with manual labor; or
- Modification of work schedules or job assignments.

Employees and job applicants have a right to be free from unlawful discrimination and retaliation

For this reason, Hillsboro School District **will not**:

- Deny employment opportunities on the basis of a need for reasonable accommodation
- Deny reasonable accommodation for known limitations, unless the accommodation would cause an undue hardship.
- Take an adverse employment action, discriminate or retaliate because the applicant or employee has inquired about, requested or used a reasonable accommodation.
- Require an applicant or an employee to accept an accommodation that is unnecessary.
- Require an employee to take family leave or any other leave, if the employer can make reasonable accommodation instead.

To request an accommodation or to discuss concerns or questions about this notice, please contact your supervisor or the benefits department @ 503-844-1518 or hsdbenefits@hsd.k12.or.us. For acquisition or modification of equipment please contact the Risk Manager.

Oregon and Federal Family and Medical Leave

Protected Leave Request

Please complete and submit this form to your supervisor or Human Resources 30 days before you anticipate taking family leave, or, if you are not able to give 30 days' notice, as far in advance as practicable. In case of an unforeseeable situation, please give your supervisor or Human Resources verbal or written notice as soon as practicable or within 24 hours before or after starting of leave.

Employee's Name:____ **District ID** _________________

Location ____

I am requesting leave for the following qualifying event:

☐ My own serious health condition.*

☐ Pregnancy disability (Includes prenatal care, childbirth and recovery). *

☐ Parental leave (includes caring for or bounding with a new child or newly placed adoptive child or foster child). *

☐ Sick child leave (Child suffers from an illness or injury that requires home care but is not a serious health condition—certification may be required after three instances of sick child leave).** Child Care -Government mandated

☐ Caring for a family member with serious health condition. *

☐ Caring for a family member who is a military service member/veteran (Form WH-385 or WH-385-V may be required).*

☐ Military family leave (Separate OMFLA request and certification my be required).

☐ Qualifying exigency leave (Form WH-384 may be required).

☐ The death of a family member.**

If applicable, the family member with a serious health condition or deceased family member is my:

☐ Spouse ☐ Domestic Partner ☐ Child ☐ Domestic partner's child ☐ Parent
☐ Parent-in-law ☐ Domestic partner's parent ☐ Grandparent ☐ Grandchild
☐ Other ______________________________________(identify the relationship)

☐ I request a block of time: ______________________ to _______________________ ; _________________________
Beginning Date Ending Date Return Date

☐ I request Intermittent Leave: _____________________ to _______________________
Beginning Date Ending Date

____ __________________________________
Employee Signature **Date**

* Certification including medical verification may be required; see the Benefits Office for additional information.

** Certification NOT required.

CONFIDENTIALITY: Medical Information provided to the employer by an employee or employee's health care provider is maintained in a confidential file.

Oregon and Federal

Family and Medical Leave

Health Care Provider Certification

This form is to be completed by physician or other health care provider and returned to the employer:
Hillsboro School District Benefits Office
Fax—503-844-1710
Email: HSDbenefits@hsd.k12.or.us

Information sought on this form relates only to the condition for which the employee is taking leave.

Employee's Name: ____

Patient's Name (if different from employee): ______________________________________

1. On the reverse of this sheet is a description of various "serious health condition" categories that qualify under the Family and Medical Leave Acts. Please check appropriate category or categories:

☐ 1-Hospital Care
☐ 2-Absence plus treatment
☐ 3-Pregnancy and/or prenatal care
☐ 4-Chronic condition requiring treatment
☐ 5-Perm/long-term condition requiring supervision
☐ 6-Multiple treatments (non-chronic condition)

2. Provide a description of the medical facts that support your certification and explain how the meet the criteria of the category:

____

____

3. Approximate date condition began and probably duration: from ___/___/___ through ___/___/___

4. Probable duration of patient's present incapacity (if different): from ___/___/___ through ___/___/___

5. If this is a chronic condition or pregnancy, is the patient presently incapacitated (see reverse side for definition)?
☐Yes ☐No If yes, duration and frequency of episodes of incapacity: ________________________.

6. Will it be necessary for the employee to take leave only intermittently or to work on a less than full-time schedule basis because of the condition or treatment? ☐Yes ☐No If yes, duration: ________________________.
Frequency: ☐One to two days per month ☐Two to three days per month ☐Three to four days per month
☐Other: Please explain how the employee will use the leave intermittently or work a less than full-time schedule, Being as specific as possible including frequency and duration of absences:

____

7. If the patient requires a regimen of treatment, what is the nature of and description of the treatments, estimated number of treatments, and intervals between treatments (see reverse side for definition)? ____________________

____

What are the actual or estimated dates of visits for treatment, or frequency of visits for treatment? ____________
What is the duration of each treatment and any period required for recovery? ________________________

8. **If this certification relates to the employee's seriously ill family member(s), also complete the following:**

a. Does the patient require assistance for base medical or personal needs, safety, or for transportation? ☐Yes ☐No

b. If no, would the employee's presence to provide psychological comfort be beneficial or assist in the patient's recovery?
☐Yes ☐No

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probably duration and frequency of this need: ____

________________________________ ________________________
Printed Name of Physician / Practitioner Date Signed

________________________________ ________________________
Signature of Physician / Practitioner Type of Practice / Field of Specialization

________________________________ ________________________
Address Phone Number

HEALTH CARE PROVIDER CERTIFICATION form (continued)

Federal and Oregon Family and Medical Leave Acts

Definition of a “Serious Health Condition”:

1. Hospital care -

Inpatient care (i.e., overnight stay) in a hospital, hospice, or a residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence plus treatment -

A period of incapacity of more than three consecutive calendar days (including any period of incapacity or subsequent treatment relating to the same condition), that also involves:

a) Treatments two or more times by a licensed healthcare provider, nurse, or physician’s assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider ***or***

b) Treatment by a healthcare provider on a least one occasion which results in a regimen of continuing treatment under supervision of the healthcare provider.

(1) Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment DOES NOT include routine physical, dental, or eye examinations.

(2) A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment DOES NOT include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or any other similar activities that can be initiated without a visit to a healthcare provider.

3. Pregnancy -

Any period of incapacity due to pregnancy, pregnancy-related illness, or for prenatal care.

4. Chronic conditions requiring treatments -

A chronic serious health condition is on which:

a) Requires periodic visits for treatment by a healthcare provider, nurse, or physicians’s assistant under direct supervision of a healthcare provider;

b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

c) May cause episodic rather than continuing periods of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent / long-term conditions requiring supervision—

A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider. Examples include Alzheimer’s, a severe stroke or the terminal states of a disease.

6. Multiple treatments (non-chronic conditions) -

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either of restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

Definition of “Incapacitated”: Inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

Directions regarding “Regimen of treatment” (question 5): If the patient is under your supervision, provide a general description of such regimen, such as prescription drugs or physical therapy requiring special equipment. If the treatments will be provided by another provider of health services, such as a physical therapist, please state the nature of the treatments.

Return form to:
Hillsboro SD Benefits
503-844-1710 Fax
HSDbenefits@hsd.k12.or.us

FITNESS-FOR-DUTY ANALYSIS

Name of worker	Date
Description of Injury or Diagnosis	

1. Employee's medical or mental health condition is stable? ☐ Yes ☐ No Next scheduled appointment date: ____________________
2. Employee's medical or mental health condition:
   - ☐ Does not allow employee to return to work **(Please provide commentary in section 11)**
   - ☐ Allows release to return to work in the following capacity:

☐ full duty without limitations Date ______________ **(Skip lines 3 through 11 and Sign below)**
☐ restricted duty from (date) ____________ through (date) ____________________ **(Specify limitations below.)**
☐ restricted hours —
specify ________________________ from (date) ______________ through (date) ______________

Hours:	**No limitations**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
3. In an eight-hour workday, worker can stand/walk a total of	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. At one time, worker can stand/walk	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. In an eight-hour workday, worker can sit a total of	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. At one time, worker can sit	☐	☐	☐	☐	☐	☐	☐	☐	☐

7. The worker is released to return to work in the following range for lifting, carrying, pushing/pulling:

Pounds	**<10**	**10**	**15**	**20**	**25**	**30**	**35**	**40**	**45**	**50**	**55**	**60**	**65**	**70**	**75**	**80**	**85**	**90**	**95**	**100**	**>100**
Occasionally	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequently	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

8. Worker can use hands for repetitive:	**Right**	**Left**	
a. Fine manipulation	☐ Yes ☐ No	☐ Yes ☐ No	Dominant hand
b. Pushing and pulling	☐ Yes ☐ No	☐ Yes ☐ No	☐ Right ☐ Left
c. Simple grasping	☐ Yes ☐ No	☐ Yes ☐ No	
d. Keyboarding	☐ Yes ☐ No	☐ Yes ☐ No	

9. Worker can use feet for repetitive raising and pushing (as in operating foot controls): ☐ Yes ☐ No

10. Worker is able to:	**Continuous 67-100% of the day**	**Frequently 34-66% of the day**	**Occasionally 6-33% of the day**	**Intermittently 1-5% of the day**	**Not at all**
a. Stoop/bend	☐	☐	☐	☐	☐
b. Crouch	☐	☐	☐	☐	☐
c. Crawl	☐	☐	☐	☐	☐
d. Kneel	☐	☐	☐	☐	☐
e. Twist	☐	☐	☐	☐	☐
f. Balance	☐	☐	☐	☐	☐
g. Reach	☐	☐	☐	☐	☐
h. Push/pull	☐	☐	☐	☐	☐
i. Climb (ladder)	☐	☐	☐	☐	☐
j. Climb (stairs)	☐	☐	☐	☐	☐

11. Other functional limitations or modifications necessary in worker's employment:

Additional comments may be written on back of form.

Signature of medical service provider	Printed name	Date

HILLSBORO SCHOOL DISTRICT 1J
PHYSICAL CAPACITIES TEST

Transportation Assistant

Employee Name: ______________________________

I STEP TEST

Standard: Level A: Successfully completing one circuit of ascending and descending two 17 1/2 inch steps.

Level A: ________ ________
Pass Fail

Level B: Successfully completing an exit from 42 inches in 10 seconds or less without jumping.

Level B: ________ ________
Pass Fail

II PUSH / PULL

Standard: Level A: Successfully completing one push/pull motion with a force of at least 30 pounds.

Level A: ________ ________
Pass Fail

III FLEXIBILITY

Standard: Level A: Bend and lift 40 pounds and place on wheel chair and push wheel chair onto platform.

Level A: ________ ________
Pass Fail

Level B: Bend, squat, kneel, reach, crawl and connect straps to secure wheel chair. Unhook the straps and lift weight off chair and place on floor. Complete in 5 minutes of less

Level B: ________ ________
Pass Fail

IV DRAG

Standard: Level A: Drag a 125 pound bag 30 feet in 30 seconds or less.

Level A: ________ ________
Pass Fail

Evaluator Name: ______________________________ **Date:** ____________________

Fitness-for-Duty Analysis Form
Physical Agility Test – School Bus Driver

Before returning to the School Bus Driver position after medical leave, employees may be required to successfully complete a Physical Agility Test, demonstrating the ability to perform the activities listed below. This form must be completed by the physician and approved by Human Resources before the employee will be scheduled to take the Physical Agility Test.

Employee Name:	**Location: Transportation Department**
Position: Bus Driver	**Employer: Hillsboro School District**

Medical Condition:	
Diagnosis:	
Treatment Administered:	
Physician:	**Current Date:**

Please indicate whether this employee is released to perform the following activities:

Physical Requirements of the Physical Agility Test	Yes	No	Comments / Restrictions
Successfully completing one circuit of ascending and descending two 17.5-inch steps			
Successfully completing an exit from 42 inches in 10 seconds or less			
Successfully completing one push/pull motion with a force of at least 30 pounds			
Drag a 125-pound bag 30 feet in 30 seconds or less			
Depress a brake pedal with the foot to a pressure of at least 90 pounds. Right Foot.			
Depress a clutch pedal with the foot to a pressure of at least 40 pounds. Left Foot.			
Reaction time of ¾ second or less from throttle to brake.			
Ability to operate two-hand and two-foot controls simultaneously and quickly.			

The employee is able to physically perform the work tasks as described above, effective ______________ (date).

☐ **Condition is temporary. Estimated end date __________________**	☐ **Condition is permanent**

____ __________________________

Physician's Signature ***Date***