UNITED STATES POSTAL SERVICE®

Employee Reassignment/Change of Craft Medical Assessment Questionnaire

Employee Name: *(Print)* KIMBERLY S. | **EIN:**

Position Offered: CITY CARRIER | **Installation:** PORTSMOUTH OH

Current Position: MAIL PROCESSING CLERK NTFT | **Installation:** ASHLAND KY

Instructions for HR Generalist (or Designee):

If a medical assessment is required for this placement, use this document and follow the steps below (see HBK EL-312, Chapter 5).

1. Ask the manager or supervisor (with input from a knowledgeable employee, if appropriate) to identify requirements and factors that describe the offered position by circling the appropriate items in Section A.
2. Have the employee review the circled items, answer the questions in Sections A and B, and sign where indicated.
3. If the employee (a) indicates functional requirements or environmental factors that he or she cannot perform or requires accommodation to perform, or (b) answers YES to any question in Section B, forward this document to Occupational Health Services (OHS) for further assessment.
4. If the employee (a) indicates that he or she is able to perform in the position, and (b) answers NO to each question in Section B, there is no need for further assessment. Forward this document to OHS for filing in the Employee Medical Folder.

Privacy Act Statement: Your information will be used to determine your suitability for the position to which you are being assigned and if necessary how best to accommodate your disabilities. Collection is authorized by 39 U.S.C. 401, 410, 1001, 1005, and 1206.

Providing the information is voluntary, but if not provided, your assessment will not be processed. We may disclose your information as follows: in relevant legal proceedings; to law enforcement when the U.S. Postal Service (USPS) or requesting agency becomes aware of a violation of law; to a congressional office at your request; to entities or indididuals under contract with USPS; to entities authorized to perform audits; to labor organizations as required by law; to federal, state, local or foreign government agencies regarding personnel matters; to the Equal Employment Opportunity Commission; and to the Merit Systems Protection Board or Office of Special Counsel.

A. Functional Requirements and Environmental Factors

Employee: Please review the Privacy Act Statement above and the circled items in the box below regarding the position you have been offered. *If you cannot perform or you require reasonable accommodation to perform any of the job's requirements or factors,* please identify the requirement or factor by number and provide a phone number to reach you between 9 a.m. and 5 p. m.

Daytime Phone:

Functional Requirements:	Environmental Factors:
1. Heavy lifting, up to 70 pounds	1. Outside
2. Moderate lifting, 15-44 pounds	2. Outside and inside
3. Light lifting, under 15 pounds	3. Excessive heat
4. Heavy carrying, 45 pounds and over	4. Excessive cold
5. Moderate carrying, 14-44 pounds	5. Excessive humidity
6. Light carrying, under 15 pounds	6. Excessive dampness or chilling
7. Straight pulling	7. Dry atmospheric conditions
8. Pulling hand over hand	8. Excessive noise, intermittent
9. Reaching above shoulder	9. Constant noise
10. Use of fingers	10. Dust
11. Both hands are required or compensated by the use of acceptable prosthesis	11. Fumes, smoke, or gases
12. Walking	12. Solvents (degreasing agents)
13. Standing	13. Grease and oils
14. Crawling	14. Radiant energy
15. Kneeling	15. Electrical energy
16. Repeated bending	16. Slippery or uneven walking surface
17. Climbing, legs only	17. Working around machinery with moving parts
18. Climbing, use of legs and arms	18. Working around moving objects or vehicles
19. Both legs required	19. Working on ladders or scaffolding
20. Operation of crane, truck, tractor, or motor vehicle	20. Working below ground
21. Ability to perform rapid mental and muscular coordination simultaneously	21. Unusual fatigue factors: Specify
22. Ability to use firearms	22. Working with hands in water
23. Other: Specify	23. Explosives
	24. Vibration
	25. Working closely with others
	26. Working alone
	27. Protracted or irregular hours of work
	28. Other: Specify

B. Medical Assessment Questions

Employee: Please review the questions below, check either YES or NO to indicate your answer, and sign where indicated. **Do not provide additional information regarding your medical history on this form.**

YES	NO	
☐	☐	1. Do you have any physical or mental condition or medical limitations that could interfere with your ability to perform the job to which you are being assigned?
☐	☐	2. Are you currently being treated by a medical provider for any health condition that may impair your ability to perform the job to which you are being assigned?
☐	☐	3. Are you currently taking any medication for this condition or any other condition that may impair your ability to perform the job to which you are being assigned?
☐	☐	4. Do you now have or have you in the past 2 years had work restrictions imposed by a treating provider that would affect your ability to perform the job to which you are being assigned?
☐	☐	5. Do you have any medical condition that limits your activities of daily living?

Medical Authorization and Release: This constitutes my consent and authorization to any health care provider, employer, or other person to disclose to any duly authorized U.S. Postal Service (USPS) employment or health official, or to a contractor acting on behalf of the USPS, any information or records concerning my health or medical history as may be relevant and necessary for a determination of my physical and medical suitability for reassignment/change of craft to a more physically demanding position. This authorization is executed with full knowledge and understanding that the USPS will take measures to protect the aforementioned information against unauthorized disclosure to any parties not having a legitimate need for it in the discharge of official USPS business.

Employee Signature	**Date** *(MM/DD/YYYY)*

If you have:

1. **Identified job requirements from Section A that you cannot perform or require accommodation to perform; and/or**
2. **Answered YES to any question in Section B, this document will be forwarded to the Occupational Health Services District Nurse Administrator for discussion with you and further assessment. Please note that you may be referred for a focused physical examination with a physician following the discussion. (For the purposes of the Postal Service, a "focused physical examination" is the medical assessment of a specific body part or system conducted by a specialist.)**