Temporary Modified Duty Assignment

EMPLOYEE NAME	DATE OF INJURY	DATE RETURNED TO MODIFIED DUTY

This assignment is available IMMEDIATELY until _____ (date)

JOB AND PAY DATA

☐ Full Time ☐ Part Time – Shift / Days off	AGENCY / LOCATION
SUPERVISOR	PHONE NUMBER

DUTIES ASSIGNED PURSUANT TO PHYSICAL REQUIREMENTS

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THESE JOB DUTIES DO NOT HAVE THE FOLLOWING PHYSICAL REQUIREMENTS

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SUPERVISOR STATEMENT

I have designed this assignment based on the treating physician's Physical Capabilities Worksheet

SUPERVISOR SIGNATURE	Date

EMPLOYEE STATEMENT

I have read and understand the physician's Physical Capabilities Worksheet. I have read and understand this Temporary Modified Duty Assignment. I agree to work within the restrictions identified. If I have any questions or feel I am being asked to work beyond these restrictions, I will notify my supervisor immediately.

EMPLOYEE SIGNATURE	Date

This form must be completed, signed and returned to the supervisor prior to commencement of the temporary modified duty work.

FOR OFFICE USE ONLY

Original to Company Human Resources

Copy to Supervisor

Copy to Employee

Copy to KESA