

Transitional Duty Assignment Form



Employee: _____

Date of Injury: _____

Department: _____

We have received your medical release from your doctor dated _____ and we are pleased you are able to return to work.

Your release form states you return to work with the following medical restrictions:

Please note your department is able to accommodate the above restrictions; your modified duties begin on: _____

Depending on the nature of your restrictions, the transitional assignment may not differ from your regular job. Your modified duties are as follows:

This is not a permanent position. It was created to assist you with returning to work. Periodically, the Physician will evaluate your progress and, if appropriate, adjustments in the work assignment will be made. We want to assist you in a safe transition from injury to return to regular work. However, you must take primary responsibility for your own safety. You are responsible to work within your restrictions. Please notify your supervisor immediately if you encounter any problems with your work assignment. By signing below, you agree to work within and understand the restrictions established by your physician.

Employee Acceptance

Employee Refusal*

Employee's Signature Date

Employee's Signature Date

Supervisor's Signature Date

Supervisor's Signature Date

- If you refuse the assignment, you may not be eligible for worker's comp disability benefits.

Please send completed form to Risk Management.