(Company Name) Transitional Work Assignment Form

Name of employee: _____ Department: _____

Date of Injury: _____Job Title: _____ Supervisor: _____

Your physician has completed a Return to Work Form which indicates that you are medically stable to participate in transitional work activities. (Company Name) has considered the restrictions identified by your physician to identify safe, meaningful and productive work activities that are within your physical abilities.

Temporary Restrictions

(Company Name) has been informed by _____on_____ that you have the following
(Physician) (Date)

temporary work restrictions:

_____

_____

_____

_____

Temporary Work Assignments

You are expected to return to work on _____on _____A.M. P.M.
(Date) (Time)

You are scheduled t work _____per day, _____per week. Your initial work assignments

will consist of performing the following work activities:

_____

_____

_____

_____

These work activities are valid through _____.
(Date)

The length of the Transitional Work Program is 60 days maximum and your assigned work activities may change at any time during your involvement in the program. This will be based on your progress and changes in your restrictions, as agreed upon by your physician. The goal for the Transitional work Program is to provide you with safe transition from injury to returning to your normal job duties. However, you are responsible for adhering to your medical restrictions at work and away form work. You must notify your supervisor if your experience difficulties performing your assigned work activities. By signing this form, you agree to work within the restriction established by your physician as indicated above.

Employee Consent

_____ _____
Employee Signature Date

_____ _____
TWP Coordinator Signature Date

Employee Refusal

_____ _____
Employee Signature Date

*Refusal to accept a transitional work assignment approved by your physician may result in discontinuation of workers' compensation benefits.