SAMPLE 2

TEMPORARY MODIFIED WORK ASSIGNMENT – RETURN TO WORK

Employee: ***Name*** DOI: ***Date of injury***

Based on medical documentation dated October 15, 2003, provided by your physician, ***Physician Name***., we currently have a Temporary Modified Work Assignment available. This will enable you to return to work in a setting appropriate for your physical capabilities and restrictions.

According to ***Physician Name***, based on your injury from ***Date***, you may engage in work activities for 8 hours a day that adheres to the following conditions:

- **No lifting more than 10 pounds**
- **Data entry limited to 2 hours at a time**
- **Alternate data entry, filing and other clerical duties**
- **Stretch 1 minute every 30 minutes**
- **Alternate sitting and standing as needed**

Your Temporary Modified Work Assignment will include the following modified duties:

- **Data Entry** - Entry of words and numbers from documents into preformatted data screens using Access or similar software. Requires digital/keyboard acuity with repetitive motion of typing and reading documents and data screen for extended periods.
- **Telephone Coverage**- Answer telephones and take messages or route calls using reference sheet. Task will involve sitting or standing at desk. Description of motion includes use of arms and hands, which can be adapted to headset to reduce grip requirements. Writing will be required for duplicate message books or work tickets.
- **General office tasks** – Combination of telephone answering and message task, with additional functions including mail opening and distribution, filing, data entry, collating, P. O. distribution, and miscellaneous clerical work. Work will be done primarily in a sitting position at a desk. Repetitive manual motions may include typing, opening and closing drawers, standing, reaching and bending. No lifting over 15 pounds is required.

You are expected to work all available hours and will not be compensated for lost time that has not been approved by your treating physician. Failure to report to work as stated above will result in an interruption or discontinuation of your partial disability benefits.

It is your responsibility to inform your supervisor and the department's Human Resources Office of any change in restrictions or work status that has been determined by your treating physician. You are responsible for informing your supervisor and the department Human Resources Office if any problems arise during the course of this temporary modified work assignment.

SAMPLE 2

The following signatures acknowledge receipt and understanding of the above-described temporary modified work assignment.

Please contact Human Resources Office at ____________________, if you have any questions concerning your temporary disability benefits.

____ ________________________
(Signature of Employee) (Date)

____ ________________________
(Signature of Supervisor) (Date)