NORTH ORANGE COUNTY
COMMUNITY COLLEGE DISTRICT

Modified Duty/Transitional Duty

Employee Name: _____

Classification/ Job Title: _____

Location: _____

Date of Injury: _____

Date Assigned to Modified/Transitional Duty: _____

Description of Work restrictions per Treating or other Physician: (Doctor name / Date and Restrictions)

Description of Accommodation(s) Offered: (Identify temporary accommodations – be specific, location, duration)

I agree to follow the work restrictions as prescribed above by Dr. _____. I understand that I need to adhere to the agreed upon temporary restrictions and accommodations, and that the North Orange County Community College District may have to end this assignment or take appropriate administrative action if I do not. I also understand that if I am asked to perform any work assignments or activities that exceed my work restrictions, I will immediately report the situation to my direct supervisor and Risk Management/Human Resources, and that I will not perform these activities.
Furthermore, I will immediately report to my direct supervisor and the Risk Management/Human Resources if any of the work restriction(s)/ accommodation(s) cause me discomfort or makes my medical condition worse.

I understand that a temporary modified/transitional duty assignment is for a maximum of ___ **days**, contingent upon clarification of work restrictions, and/or review of status. I understand that the purpose of temporary modified or transitional duty is to allow for medical improvement. I understand that this is a temporary assignment only and does not imply entitlement to a permanently modified position.

Supervisor's Signature: _____ **Date:** _____

HR/RM Signature: _____ **Date:** _____

Employee's Signature: _____ **Date:** _____

Date of Approval: ___ **Signature:** _____

Comments:

***** Attach copy of employees return to work physicians notice