Non-Safety Temporary Modified Duty/Transitional Duty

Employee Name:	
Classification/Job Title:	
Location:	
Date of Injury or Illness Onset:	
Date Assigned to Modified/Transitional Duty:	

Description of Work Restrictions, per Treating Physician:*

Description of Accommodation(s) Offered:

I agree to follow the work restrictions as prescribed above by my treating physician. I understand that I need to adhere to the agreed upon temporary restrictions and accommodations, and that the City of Oxnard 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 the Human Resources Director, and that I will not perform these activities. Furthermore, I will immediately report to my direct supervisor and the Human Resources Director if any of the work restriction(s)/ accommodations(s) cause me discomfort or make any medical condition worse.

I understand that a temporary modified/transitional duty is contingent upon approval at 90-day intervals, and does not imply entitlement to a permanently modified position.

Supervisor's Signature:		**Date:**
Employee's Signature:		**Date:**
Human Resources Signature:		**Date:**

The Department Director approves assignments exceeding 90 days. Date:

Date of Approval: Signature:

Last date of modified/transitional duty: Comments:

This is a temporary assignment and your Department Director can discontinue at their discretion.

* Attach copy of employee's return to work physician's notice.