**ORGANIZATION NAME**

**DISABILITY INTERACTIVE PROCESS / REASONABLE ACCOMMODATION**

***Temporary Modified/Light Duty Agreement***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Employee Name** | |  | | | | | |
| **Classification/ Job Title** | | |  | | | | |
| **Location** |  | | | | | | |
| **Date of Injury/ Onset of Illness** | | | |  | | | |
| **Date Assigned to Temporary Light Duty by Health Care Provider:** | | | | | | | |
| **Assignment Start Date:** | | | | | | | **Assignment End Date:** |
| **Description of Work Restrictions, per Health Care Provider (List specifically what is stated in medical note)** | | | | | | | |
|  | | | | | | | |
| **Assignment Type Offered ❑ Modified ❑ Light Duty**  **Description of Accommodation(s) Offered:** | | | | | | | |
|  | | | | | | | |
| **Work Schedule ❑Unchanged ❑ Changed** | | | | | **Work Hours per Day from \_\_\_\_\_\_\_\_\_\_ am/pm to \_\_\_\_\_\_\_\_\_\_ am/pm** | | |
| **Assigned Supervisor’s Name, if different** | | | | |  | | |
| **Assignment Not Available. Reason/Discussion Points** | | | | | |  | |

I agree to follow and adhere to the temporary work restrictions as prescribed above by my treating Health Care Provider. I also understand if I am asked to perform any work assignments or activities that I believe are unsafe or exceed my work restrictions, I will immediately report the situation to my direct supervisor and Human Resources, and I will not perform these activities. I also agree I will immediately report to my direct supervisor and to Human Resources if any of the job activity causes me discomfort, is causing pain or makes my medical condition worse.

I understand my employer has offered me a TMLD assignment as a way to support me to maintain work patterns and income while I continue to medically improve. I understand TMLD assignments typically will not normally exceed a maximum of 90 days, and this TMLD Assignment does not imply entitlement to a permanently modified position. This TMLD assignment may be extended upon approval at 45-day intervals if I continue to medically improve, as evidenced by reduced restrictions. I understand it is my responsibility to provide Human Resources with a new medical notice at the conclusion of the initial approval period. I understand this approval period ends on the date listed above and will not be extended, and my TMLD Assignment may be ended, unless I provide additional needed medical certification. I also understand that this assignment will end immediately when my condition has reached permanent and stationary status and if I am provided with permanent work restrictions.

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| --- | --- | --- | --- |
| **HR Signature:** |  | **Date:** |  |
| **Employee’s Signature:** |  | **Date:** |  |
| **Supervisor’s Signature:** |  | **Date:** |  |