
Company Name

Date

Employee Name (print)

EMPLOYEE NOTIFICATION OF TEMPORARY LIGHT DUTY

It is the intent of our company to provide a safe and productive environment for all of our employees, and to provide light duty assignments for our injured workers. If you have been injured and need accommodations regarding your work assignments we will make every effort to provide work within the limitations set by the treating physician.

It is the employee's responsibility to provide their supervisor and the personnel office with a copy of the work restrictions given by the physician, within 1 day of having been released to work by the treating physician regardless of the limitation. This must be done each time your restrictions are changed by the treating physician.

You are required to follow-up with any necessary medical care as recommended by the doctor. These visits should be scheduled after regular work hours or before your shift begins, if at all possible. If you need assistance with scheduling appointments we will assist you with getting the necessary information from our insurance company.

The light duty assignments will be scheduled, and you must report to work on time as with any regular assignment. Transportation to and from work, as well as to and from the medical visits remains your responsibility. You must **not** exceed the work restrictions of the treating physician and if there are questions regarding your work assignments those questions should be addressed with your supervisor or manager

Your rate of pay will be the same if you are doing essentially the same work, but may be reduced if the work you are assigned is unrelated to your regular tasks. Your other benefits will remain the same during the period you are working temporary light duty.

This information has been explained to the employee and they are aware of our company policy regarding light duty.

Signature of Employee

Print Name

Date

Signature of Employer Representative

Print Name

Date

Date

Company Name

Employee Name (print)

Date of Injury

CONFIRMATION OF LIGHT DUTY JOB OFFER

_____ has offered _____ a temporary light duty job
Employer Name Employee Name
of _____ that falls within the limitations and restrictions established by
Job Title

_____ on _____. It is the injured workers responsibility to work
Doctors Name or Clinic Name date

within the limitations established by the treating physician. If the restrictions are changed the employee must bring the new restrictions to his supervisor and the office within 1 day of seeing the doctor, so any changes in assignments can be made if modified work remains available.

Employee Signature Employee Name (print) Date

Employer Representative Signature Employer Representation (print) Date