EARLY & SAFE RETURN TO WORK PROGRAM – MODIFIED WORK ASSIGNMENT

EMPLOYEE NAME: _____

POSITION: _____

DATE OF DISABILITY: _____

☐Occupational ☐Non-Occupational

Estimated Length of Disability: _____

Nature of Modified Work Assignment:

_____

_____

_____

_____

Requested by:

_____ _____

Supervisor Name & Signature *Date*

Agreed to by:

_____ _____

Employee Name & Signature *Date*

Approved by:

_____ _____

Site Superintendent Name & Signature *Date*

A request for MODIFIED WORK or LIGHT RETURN TO WORK ASSIGNMENT will only be considered if a medical doctor authorizes approval prior to starting.

REFUSAL OF MODIFIED DUTIES:

I, the undersigned, understand the Modified Work Duties outlined by my employer and refuse to participate in the said program.

_____ _____

EMPLOYEE NAME & SIGNATURE **DATE**