RETURN TO WORK ACKNOWLEDGEMENT

Employee Name _____

Address: _____

City, State, Zip: _____

Incident/Accident Date: _____ **Department:** _____

Is the employee's modified duty ☐ Temporary or ☐ Permanent?

Dates for Temporary Modified Duty: _____

List physical or mental restrictions as noted by physician **(attach physician's documentation)**. It is understood that any modifications to the restrictions may only be changed by the attending physician.

1. _____
2. _____
3. _____
4. _____
5. _____

List any accommodations being provided; if needed use a separate sheet to document conditions, expectations, and requirements for this temporary modified duty assignment.

1. _____
2. _____
3. _____
4. _____
5. _____

I understand that I am required to follow my physician's physical and/or mental restriction(s) and that the restriction(s) has been discussed with me. I also understand that I am required to work safely and perform my duties in a manner that is consistent with the performance standards as set forth by Montgomery County Government. I understand that failure to follow these restrictions could affect my OJI and employment rights.

Employee Signature	Date	Supervisor's Signature	Date