

Confirmation of Transitional Duty

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This form is completed by the employee and submitted to the Supervisor or Department Head when the employee is returning to work following an injury or illness, confirming the commencement of a Transitional Duty/Return-to-Work assignment and again at the resumption of regular duty, or an alternate regular assignment.

To be completed by the Employee	
Employee Name:	Dept
Position: Da	ate of Injury/Temporary Disability:
☐ Work Related Injury/Disability ☐ Non-Work Related Injury/Disability	
Supervisor's Name:	Phone:
Date available for Alternate Duty or to return to work (start date):	
Next Medical Evaluation Date:	
To be completed by the Supervisor or Department Head	
Employee resumed regular day/alternate regular assignment on: (start date)	
Were you able to accommodate the job modifications as described by the physician? $\ \square$ yes $\ \square$ no	
If the job modifications were altered from the physician/s recommendations, please describe below:	
Employee Signature	Date
Department Head/Supervisor Signature	 Date