**Fire Temporary Modified Duty/Transitional Duty**

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| Employee Name: |  |
| Classification/Job Title: |  |
| Location: |  |
| Date of Injury or Illness Onset: |  |
| Date Assigned to Modified/Transitional Duty: |  |

 **Description of Work Restrictions, per Treating Physician:\***

**Description of Accommodation(s) Offered:**

I agree to follow the work restrictions as prescribed above by my treating physician. I understand that I need to adhere to the agreed upon temporary restrictions and accommodations, and that the City of Oxnard may have to end this assignment or take appropriate administrative action if I do not. I also understand that if I am asked to perform any work assignments or activities that exceed my work restrictions, I will immediately report the situation to my direct supervisor and the Human Resources Director, and that I will not perform these activities. Furthermore, I will immediately report to my direct supervisor and the Human Resources Director if any of the work restriction(s)/ accommodations(s) cause me discomfort or make any medical condition worse.

I understand that a temporary modified/transitional duty is contingent upon approval at 90-day intervals, and does not imply entitlement to a permanently modified position.

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| Supervisor’s Signature: |  | Date: |
| Employee’s Signature: |  | **Date:** |
| Human Resources Signature: |  | **Date:** |

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| The Department Director approves assignments exceeding 90 days. |  | Date: |
| Date of Approval: |  | Signature: |
| Last date of modified/transitional duty: |  | Comments:  |

This is a temporary assignment and your Department Director can discontinue at their discretion.

\* Attach copy of employee’s return to work physician’s notice.