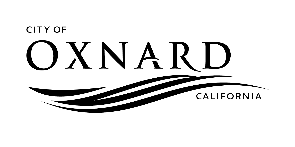
**Fire Temporary Modified Duty/Transitional Duty**

|  |  |
| --- | --- |
| 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.

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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.