Print Form

San Joaquin County
Human Resources Division
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Stockton, California 95202
Phone: (209) 468-3370 Fax: (209) 953-7330

RETURN TO WORK ACKNOWLEDGEMENT

Employee Name: _____ ID: _____

Incident/Accident Date: _____ Department: _____

Is the employee's modified duty TEMPORARY or PERMANENT? _____

List physical or mental restrictions as noted by physician (attach separate sheet as necessary):

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

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

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

I understand that I am required to follow my physician's physical and/or mental restrictions. I also understand that I am required to work safely and perform my duties in a manner that is consistent with the customer service and performance standards as set forth by San Joaquin County.

Employee Signature _____ Date: _____

TEMPORARY MODIFIED DUTY INFORMATION
(To be completed by Department designee only)

1. Modified duty start date: _____
1a. Modified duty end date: _____
2. What is the duration of the temporary modified duty: _____ Months _____ Days
3. If an extension of temporary modified duty is requested, please contact Disability Management to discuss feasibility
4. Was extension of modified duty approved? ☐ Yes ☐ No
5. If yes to question 4, state length of duration: _____ Months _____ Days
6. If no to question 4, state the reason: _____

Supervisor Signature: _____ Date: _____

I have communicated to the employee the duration, conditions, requirements, and expectations of this temporary modified duty assignment.