San Joaquin County
Human Resources Division
44 N. San Joaquin Street, Suite 330
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.

Revised 06/2006
Updated Address Revision 9/09