



## RESTRICTED WORK PLAN

Employee: \_\_\_\_\_

Department: \_\_\_\_\_

Supervisor: \_\_\_\_\_

Title: \_\_\_\_\_

It is excellent that the restrictions required by your health condition allow you to perform work and we welcome your return to the workplace. We have identified a work assignment that we believe to be within your restrictions. If the assignment exceeds your restrictions we will provide applicable and reasonable temporary accommodation as available.

A restricted work assignment may be available if required due to the medical condition. You will return to your full responsibilities, when you are medically released to full duty and your restrictions no longer impact performance of your position's responsibilities or when you have been determined to have permanent restrictions that require reasonable accommodation for you to perform your full responsibilities.

Participation in restricted work requires submission of medical documentation following each medical appointment. You will not be able to work without submission of the medical documentation as we will not know your restrictions and abilities. **Use the following sentence for work related restrictions.** The medical documentation (Patient Status Report or document with similar information) must be received by the appropriate department staff member within twenty-four (24) hours/one business day of each medical appointment. **Use the following sentence for non-work related restrictions.** The medical documentation identifying your restrictions must be received by the appropriate department staff member. The medical documentation must be timely.

You need to inform me immediately if you experience difficulty in performing the work assignment for determination of other accommodation needs. If you are experiencing difficulties in performing work within your restrictions, you may need to be referred back to the treatment health provider.

You will return to work on \_\_\_\_\_ on \_\_\_\_\_ work schedule in \_\_\_\_\_ unit  
Month/Day/Year      Work/Shift Hours      Unit/Department Name  
or department. On the first day, please report to \_\_\_\_\_ in this unit or  
Person's Name  
department to begin work. We will review your restriction needs on receipt of each new medical document to determine necessary changes in the restricted work assignment.

By your signature below, you agree to perform the assigned work tasks to the best of your ability within your medical restrictions.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

*The department should attach a description of the tasks assigned during the restricted work assignment.*