

Temporary Modified Work Assignment / Job Injury

EMPLOYEE NAME (PRINT)

____/____/____
CURRENT DATE

OR _____
Employee ID Number

____/____/____
DATE OF INJURY

Your attending physician has placed restrictions on your ability to do regular work which were caused by your on-the-job injury. After a review of those restrictions, we have located a position that meets the restrictions set by your physician. You will be paid at your normal regular rate of pay for all time worked on modified. This assigned location is less than 50 miles from where were injured or less than 50 miles from where you live.

You are scheduled to report to work as follows:
You will report to: _____
At the following location: _____
Starting on: ____/____/____ **Time:** ____:____ AM or PM
Your modified shift will be from ____:____ **to** ____:____
You will have the following days off: S S M T W T F
(Please mark days off)
Your job duties will be:

Modified work is available to employees who have accepted claims for on-the-job injuries. All modified work assignments are made based on the individual job requirements, the special work area requirements, physical restrictions of the employee. Temporary modified work will be terminated should suitable work no longer be available, if you are released to regular work, or if your condition changes so you can not perform these duties. While on a modified work assignment **you will not be allowed to work overtime or holidays.**

I have read and understand this assignment. I agree to work within the restrictions set by my physician.

Employee Signature

____/____/____
Date

****ORIGINAL DOCUMENT TO DAS EMPLOYEE SERVICES: 155 Cottage St U130, Salem OR 97301****