STATE OF NEVADA

TEMPORARY MODIFIED-DUTY ASSIGNMENT
FOR RECOVERING EMPLOYEES

Employee's Name_____ Claim#_____
Date of Injury_____Date Returned to Work_____Program End Date _____

This assignment is available *IMMEDIATELY* for a maximum of 90 calendar days.

JOB AND PAY DATA
_____ Unchanged from regular work. _____Changed from regular work
_____ Full-time _____ Part Time Shift/Days Off_____

Agency/Location:_____

Supervisor/(phone):_____

If part of 'Temporary Job Pool':
Regular Agency/Supervisor/Phone:_____

Duties Assigned/Physical requirements:
DUTIES: % TIME/SHIFT
_____

_____

_____

These job duties do not have the following physical requirements:

_____

_____

Supervisor Statement:
I have designed this assignment based on the treating physician's medical restrictions. If I or the employee have any questions regarding the medical appropriateness of this assignment, I will contact the doctor immediately.

_____
Supervisor Signature/Date

Employee:
I have read and understand this temporary assignment. I agree to work within the restrictions listed. If I have any questions or feel I am being asked to work beyond my capabilities, I will notify my supervisor immediately.

_____
Employee Signature/Date

FOR OFFICIAL USE ONLY
Original to Employing Agency
Copy to Agency of Record
Copy to Employee
Copy to MCO/TPA
Copy to Risk Management if part of 'Pool of Modified Duty Jobs'