

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'