

## RETURN TO WORK ACKNOWLEDGEMENT

**Employee Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Incident/Accident Date:** \_\_\_\_\_ **Department:** \_\_\_\_\_

Is the employee's modified duty  Temporary or  Permanent?

Dates for Temporary Modified Duty: \_\_\_\_\_

List physical or mental restrictions as noted by physician (**attach physician's documentation**). It is understood that any modifications to the restrictions may only be changed by the attending physician.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

List any accommodations being provided; if needed use a separate sheet to document conditions, expectations, and requirements for this temporary modified duty assignment.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**I understand that I am required to follow my physician's physical and/or mental restriction(s) and that the restriction(s) has been discussed with me. I also understand that I am required to work safely and perform my duties in a manner that is consistent with the performance standards as set forth by Montgomery County Government. I understand that failure to follow these restrictions could affect my OJI and employment rights.**

\_\_\_\_\_  
Employee Signature                      Date                      Supervisor's Signature                      Date