MODIFIED DUTY WORK AGREEMENT

NAME:_____ DATE:_____

1. It is the purpose of this agreement to establish a modified duty assignment to prevent any misunderstanding as to the terms and time specified. This agreement is specifically designed to meet the needs of each individual, and is uniquely suited to the individual.

2. I, _____, agree to the terms of this agreement for a period of _____ from the date of this agreement, or less if released by my treating physician. I understand that notification of failure to comply with the terms of this agreement will be communicated to _____ and may result in my termination. I further understand that I must inform my supervisor if the duties I am performing are not within my treating physician's restrictions.

3. I agree to return to work and perform the duties of a _____, except as modified below:
   _____
   _____
   _____.

4. I agree to continuing medical treatment as prescribed by my treating doctor.

5. I hereby authorize the rehabilitation therapist to contact and exchange information pertaining to my temporary condition with my physician, my supervisor, the UTD Workers' Compensation Insurance Office, and the UTD Environmental Health and Safety Office. Information given will be limited to that which is reasonably necessary to assess my ability to perform job-related functions.

6. I understand that at the end of this agreement, I will be reevaluated and the following alternative will be considered:

   a. Return to full work duty with no restrictions.
   b. Recommended continued temporary reassignment, up to a maximum of three (3) months total time.
   c. Permanent transfer to a position which is consistent with my physical capabilities. Employee must bid on position and meet all job specifications.
   d. Termination of employment (in accordance with UTD Policy & Procedure for Discipline and Dismissal, D8-100.0).

7. I understand that this is not a contract for employment and that I am subject to all UTD rules, regulations and policies applicable to my employment.

APPROVED:

_____		_____	
Signature of Physician	Date	Signature of Employee	Date
_____		_____	
WCI Representative	Date	Physical Therapist (if applicable)	Date
_____			
Department Manager	Date		

(6/04)