**Model Return-To-Work Agreement**

[Date]

[Name of temporarily restricted worker]

I understand a temporary modified assignment that complies with my temporary work restrictions as identified by my designated medical professional is being offered to me.

I understand that if I am eligible for leave under the Family Medical Leave Act (FMLA), I cannot be forced to return to work. I also understand that I may lose my eligibility for certain worker’s compensation benefits for rejection of the modified assignment.

I understand this offer is for a temporary period of time.

I agree to follow the work restrictions as prescribed by the designated medical provider and understand that I need to adhere to the agreed upon temporary restrictions and accommodations. Pursuant to the healthcare provider, these restrictions may apply both at work and at non-work locations. I also understand that if I am asked to perform any work assignments or activities that exceed my work restrictions, I will immediately report the situation to my direct supervisor and that I will not perform these activities. Furthermore, I will immediately report to my direct supervisor if any of the work restriction(s)/accommodation(s) cause me discomfort or make my medical condition worse.

I understand that I should try to schedule any medical appointments during non-work time. If I am unable to do so, I understand that I need to inform my supervisor in advance of the appointment date. I understand that these appointments may fall under Family Medical Leave Act (FMLA) and it is my responsibility to apply for FMLA leave according to my employer’s policy if I cannot schedule appointments outside my work time. I understand that the time off for the appointment will be unpaid, unless otherwise covered by a paid leave policy.

I also understand that it is my responsibility to provide my supervisor with current work status reports from my physician.

I understand that a temporary modified/alternate duty assignment will be periodically reviewed and will not normally exceed 90 calendar days. This does not imply entitlement to a permanently modified position.

[Member Name] follows the provisions of the Americans with Disabilities Act (ADA) and the Iowa Civil Rights Act. If the employee believes he or she is disabled within the meaning of ADA or ICRA, then he or she should discuss that belief with the Human Resources Designee. The [Member] will engage in an interactive process with the employee to determine whether the [Member] can reasonably accommodate the employee. If [Member Name] agrees that the law applies, it will, when appropriate, consider reasonable accommodations to the employee’s regular job. If such accommodations are not reasonable or constitute an undue hardship, then other reasonable accommodations such as placement in vacant jobs where the employee is qualified or an appropriate leave of absence may be considered.

Employee Signature Date

Supervisor Signature Date

**TEMPORARY/MODIFIED ALTERNATE DUTY AGREEMENT FORM**

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Injury/Onset of Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Supervisor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Assigned to Temporary Light Duty by Physician: \_\_\_\_\_\_\_\_\_\_\_

Temporary Duty Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temporary Duty End \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Work Restrictions, per Treating Physician: (List specifically what is stated in medical note.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assignment Type:  Modified  Alternate\* (Temporary work in another position and/or location)

\*If Alternative location, Supervisor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternative location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Accommodation(s) Offered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work schedule:  Unchanged  Changed \_\_\_\_\_ Work hours per Day from \_\_\_\_\_ am/pm to \_\_\_\_\_ am/pm

Work Days:  Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday

Wage Rate: \_\_\_\_\_\_\_\_\_\_\_\_

If assignment not available - Reason/Discussion Points: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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FMLA Eligible: Yes No

I understand that I am required to report directly to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For job duty on: \_\_\_\_\_\_\_\_\_\_\_ at: \_\_\_\_\_\_\_\_\_\_ am/pm, at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The work restrictions and accommodations were reviewed with the employee on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes, I understand this agreement and I accept this work. I will comply with restrictions as prescribed by my treating physician.

No, I understand this agreement and I do not accept this work alternate work position. I understand that refusal of this return to work offer may adversely affect my worker’s compensation benefits.

I refuse this offer of work restrictions and accommodations because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_