☐ **On the Job Injury/Illness –**
Workers' Compensation

☐ **Off the Job Injury/Illness**

MEDICAL WORK RESTRICTION AGREEMENT

Medical Work Restriction for: _____ Today's date _____

Department & Contact: _____ Phone No# _____

Date of Injury: _____ Claim No#: _____

Effective: _____

Your doctor has placed the following medical work restrictions on your activities:

-
-
-
-

Affected Body part:

The above restriction is temporary until:

Next doctor appointment: Date: Time:

(Please provide) *current work status reports are necessary to avoid interruption in benefit payments

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EMPLOYEE AGREEMENT TO MEDICAL WORK RESTRICITON(S)

I, the undersigned, have been advised that medical restrictions have been placed on my activities while performing duties within the scope of my employment. I have read and understand the medical restrictions as detailed above. I further understand that it is my responsibility not to violate these restrictions. I further understand and agree that if a supervisor requests that I perform duties that would violate these restrictions; I will immediately advise that supervisor and other management, if necessary, of my restrictions. ***I further agree to keep my scheduled doctor appointments and keep my supervisor informed in the event my doctor changes these restrictions****.*

I acknowledge that time away from work to attend doctor appointments, medical treatment appointments and physical therapy appointments is not compensible through Workers' Compensation or through payroll. Sick time or vacation-used-as-sick time may be used, if accruals are available.

Supervisor: If this employee loses time due to this injury/illness, please fax time cards to 525-5779.

☐ Can Accommodate ☐ Can Not Accommodate

_____ _____
Signature of Employee Date

_____ _____
Signature of Supervisor Date

_____ _____
Print Supervisor's Name Phone Number

MEDICAL WORK RESTRICTION AGREEMENTS

Policy: Employees who are placed on a medical work restriction shall be required to complete the Medical Work Restriction Agreement to ensure that their activity does not go beyond the limits placed upon them by their medical provider.

Employee: Provide supervisor with doctor statement.

Supervisor:

A. Counsel the employee that it is their responsibility to **submit a work status slip after each and every doctor visit.** Should the employee fail to submit a current work status slip his or her Workers' Compensation benefits may be impacted.

B. If medical statement indicates a work restriction, supervisor shall have employee sign Medical Restriction Agreement.

C. Forward original doctor statement and Medical Work Restriction to Departmental Personnel Unit.

Personnel:

A. File a copy of the doctor statement and agreement in employee's medical file.

B. Original doctor statement and agreement shall be sent to the Disability Management Unit of the CEO-Risk Management. Copies of document will be placed in employee medical file(s) indicated in (A) above.

C. If medical statement is received by the Disability Management Unit of the CEO-Risk Management Division without the signed agreement being attached the supervisor will be contacted to complete the agreement.

When working a reduced work schedule - please fax weekly time cards to the CEO-Risk Management Division at 525-5779 to avoid unnecessary delay in benefit payments.