TRANSITIONAL WORK PLAN

Employee Name:	**Position Title:**
Agency/Facility:	**Date:**

I. Medical Information

Current Medical Restrictions: (or attach physician prescription)	
Date Restrictions Began:	Next Medical Appointment:

II. Transitional Plan

A. Describe the specific duties/tasks that will be assigned
B. % of physical, mental, and environmental demands required to perform the duty/task

Start Date:	Plan End Date:
A. Specific duties:	B. Demands:
Schedule of Hours/Day, Days/Week (include progression if appropriate):	
Special Considerations:	

III. Signatures of Agreement

I have been provided with a copy of this plan and should I experience any difficulties during my transitional work, I will discuss them with my supervisor. Any changes to these duties must first be discussed with Human Resources and approved by my treating physician.

Employee Signature:	Date:

I acknowledge that I have reviewed the transitional plan and understand that any modifications to this plan must first be approved by the treating physician.

Supervisor Signature:	Date:

I acknowledge that I have reviewed this transitional work plan and approve for my patient to participate. If you do not agree with this plan, please provide medical rationale on the back.

Physician Signature:	Date: