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STATE OF MISSOURI

EARLY RETURN TO WORK TEMPORARY MODIFIED - DUTY ASSIGNMENT

EMPLOYEE NAME	SSN

CARO NUMBER	DATE OF INJURY	DATE RETURNED TO TEMPORARY MODIFIED DUTY

This assignment is available IMMEDIATELY until _____ . (date)

JOB AND PAY DATA

☐ Full-time ☐ Part Time Shift/Days off	AGENCY/LOCATION
SUPERVISOR	PHONE NUMBER

DUTIES ASSIGNED PURSUANT TO PHYSICAL REQUIREMENTS

THESE JOB DUTIES DO NOT HAVE THE FOLLOWING PHYSICAL REQUIREMENTS

SUPERVISOR STATEMENT

I have designed this assignment based on the treating physician's temporary medical restrictions.

SUPERVISOR SIGNATURE	DATE

EMPLOYEE STATEMENT

I have read and understand the physician's temporary medical restrictions. I have read and understand this temporary assignment. I agree to work within the restrictions identified. If I have any questions or feel I am being asked to work beyond these restrictions, I will notify my supervisor immediately.

EMPLOYEE SIGNATURE	DATE

This form must be completed, signed and returned to the supervisor prior to commencement of the temporary modified duty work.

FOR OFFICIAL USE ONLY

Original to State Agency

Copy to Supervisor

Copy to Employee

Copy to OA Risk Management/CARO