

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 AGENCY/LOCATION			
Part Time Shift/Days off			
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 t	he treating physician's ten	nporary medical restriction	
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			