|  |
| --- |
| Modified Work Agreement |

Name of Employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We are pleased to offer you modified work in accordance with the functional abilities outlined by your medical professional. A medical assessment is required if any changes in your condition should occur.

|  |  |  |
| --- | --- | --- |
| **Modified Job Duties** | **Start Date** | **End Date** |
|  |  |  |
|  |  |  |
|  |  |  |

You will be paid normal rate/salary for the period of the modified work.

Your hours of work will be \_\_\_\_\_\_\_\_\_\_\_ A.M. to \_\_\_\_\_\_\_\_\_\_\_\_\_ P.M. for \_\_\_\_\_\_\_\_ hours per week.

Your weekly work schedule will be:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
|  |  |  |  |  |  |  |

If applicable, indicate number of days in cycle: \_\_\_\_\_\_\_\_\_\_\_\_ days on/ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_days off.

The length of the accommodation period will depend on your recuperation and functional abilities as given by your medical provider as well as your cooperation in the program. A medical clearance may be requested prior to continuing regular work.

The Health and Safety Representative and/or Supervisor will monitor your progress and/or any concerns you may have. If, at any point, you experience difficulties on the job, it is your responsibility to advise us immediately.

I have considered the above offer and agree to the proposed modified work duties and all conditions outlined.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have considered the above offer and decline the proposed modified work duties and all conditions. I understand that by refusing to participate in the modified work program, I may jeopardize my entitlement to workers’ compensation benefits. I agree to keep my supervisor and Workers’ Compensation informed as to my ongoing medical status and ability to return to normal duties.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This offer has been given to you by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This offer has been approved and reviewed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_