



STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

I understand that my treating physician has released me to return to transitional work, provided that I do not exceed the limitations outlined by him/her.

Employee: I agree to work within these restrictions. In the event that I am given an assignment that falls outside these restrictions or that is causing any difficulty in the performance of these duties or given an assignment beyond these restrictions, I will notify my manager/supervisor immediately. I will not violate the restrictions, as I understand them. I will work cooperatively with my manager/supervisor to prevent re-injury or aggravation of my present physical condition.

Manager: I agree to assign only work within the physician's restrictions noted above. If the employee is observed doing any job task that falls outside these restrictions, I will immediately talk with the worker to resolve these problems. I will not violate restrictions as understood. I will work cooperatively with the worker to prevent re-injury or aggravation of the worker's present physical condition.

We agree to notify the Return-to-Work Coordinator and/or Human Resources if further assistance is needed.

Employee Signature

Supervisor Signature

Effective Date

Review Date

I understand that my restrictions have been changed by my treating physician, and that I will no longer be participating in this transitional duty assignment.

Employee Signature

Supervisor Signature

Effective Date