Alameda County

Temporary Modified Work Plan

This form is to be used to document Temporary Modified Work (TMW) assignments for employees who are recovering from temporary injuries, illnesses and/or medical conditions.

Employee's Name	Classification	Department/Unit
Employee's Phone # (Wk)	**Regular Work Schedule (e.g. M-F, 8am-5pm)**	**Supervisor's Name**

Temporary Modified Work Assignment Details

*Effective Date:*_____ *End Date:* _____

Temporary Work Restrictions/Limitations
Description of TMW Assignment
Description of Modified Work Schedule (e.g. M-F, 8am-3pm)

Acknowledgement

I have reviewed the Alameda County Temporary Modified Work Plan described herein. I understand that this TMW assignment is intended to address temporary medical conditions, restrictions and/or limitations; and it is not intended to be permanent. I also understand that all temporary restrictions/limitations will be followed during this assignment. I understand that TMW assignments are based on the availability of temporary work consistent with my work restrictions/limitations and are not to exceed ninety (90) calendar days. The provision for continuing this TMW assignment will be re-evaluated every 30-45 days.

Employee's Signature	Date	Supervisor's Signature	Date

*Supervisor: Please forward to the Agency/Department's Workers' Compensation Liaison/Disability Coordinator when signatures are completed.

cc: Agency/Department Disability Coordinator
Workers' Compensation Liaison (if appropriate)
Risk Management Unit (if appropriate)
Medical File

Print Form