	HUMAN RESOURCES DESKTOP PROCEDURES		
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Purpose


To provide guidelines for approving and assigning a temporary modified light-duty assignment.

Background

Employees with Non-Occupational Injuries/Illnesses/Restrictions may be offered a voluntary opportunity to participate in a temporary modified light-duty assignment, at the College's discretion. A modified light-duty assignment allows employees who are medically restricted from performing their regular essential duties due to an injury or illness, to return to work in a modified capacity, on a temporary basis. The existence of this desktop procedure does not in any way guarantee that a modified light-duty assignment will be available at any given time, or for any particular employee who requests it. The number, availability and duration of such assignments are limited by departmental needs and in consultation with Human Resources. This procedure and process are subject to College policies, regulations and all applicable laws.

Procedure

- A. Any full-time employee who requires temporary modifications to their regular work duties as a result of a personal injury/illness/restriction may be granted a temporary modified light-duty assignment, at the College's discretion.
- B. Modified light-duty assignments are temporary assignments only, are not vacant or permanent positions within the College and are not available to employees on a permanent basis under any circumstances.
- C. Employees requesting a temporary modified light-duty assignment will adhere to the following:
 1. The employee shall notify their supervisor of the need for a temporary modified light-duty assignment and provide supporting medical documentation from their treating health care provider to Human Resources (HR).
 2. HR and the supervisor shall review the employee's limitations and determine the availability of modified work within the department.
 3. If additional supporting documentation is needed, HR shall provide the employee with a Work Status Form, to be completed by the treating health care provider.
 4. If approved, HR and the supervisor shall complete a Temporary Modified Light-Duty Agreement Form, identifying the modifications to the employee's regularly

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assigned work duties.

5. Both the employee and supervisor shall sign the Temporary Modified Light-Duty Agreement Form, signifying the agreeance to the modified terms.
 6. If the supervisor or employee has any questions regarding the medical appropriateness of the temporary assignment, HR shall be contacted for assistance who in turn may confer with the medical provider, if needed.
- D. The supervisor is responsible for monitoring the employee and ensuring that expectations under the Assignment are met.
1. Work limitations may change as the employee continues to recover from the injury, illness or restriction. When limitations change, the employee shall provide additional supporting medical documentation from their provider to HR. If appropriate, HR and the supervisor shall complete a new Temporary Modified Light-Duty Agreement Form, identifying the new modifications to the employee's regularly assigned work duties.
 2. When the employee is released to return to work with no limitations by their medial provider, the employee shall submit a Work Status Form, completed and signed by the treating health care provider, noting no restrictions and the ability to work his/her regularly scheduled duties. This form must be presented to the supervisor and HR upon the employee's return to work.
- E. Temporary modified light-duty assignments shall not exceed a period of 90 calendar days.
1. If restrictions continue beyond the initial 90-day period, the employee may be required to submit a leave of absence request.
 2. Extensions may be granted on a case-by-case basis and are based upon supporting medical documentation and the availability of modified work within the department.
 3. If at any point the employee is medically determined to have sustained permanent limitations/restrictions, the creation or continuation of a temporary modified light-duty assignment will not be considered. In that event, the College will review the employee's situation separately, to determine the appropriate steps to be taken, if any, under applicable laws and College policies.

Work Status Form

Employee's Last Name	Employee's First Name	Date of Appointment	Employee's EMPLID
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Medical Provider: The employee listed above has indicated a need for modified work based on a non-occupational injury, illness or other physical restrictions. Please complete the information below.

<input type="checkbox"/> Employee is released to return to Regular Work on (date) _____ <input type="checkbox"/> Employee is released to Modified Work from (date) _____ until (date) _____ as identified below.

Employee May:

	No restrictions	Total hours during day					Hours at one time				
		8+	6-8	4-6	2-4	0-2	8+	6-8	4-6	2-4	0-2
<input type="checkbox"/> Stand/Walk	<input type="checkbox"/>										
<input type="checkbox"/> Sit	<input type="checkbox"/>										
<input type="checkbox"/> Drive	<input type="checkbox"/>										
<input type="checkbox"/> Bend	<input type="checkbox"/>										
<input type="checkbox"/> Squat	<input type="checkbox"/>										
<input type="checkbox"/> Kneel	<input type="checkbox"/>										
<input type="checkbox"/> Climb	<input type="checkbox"/>										
<input type="checkbox"/> Twist	<input type="checkbox"/>										
<input type="checkbox"/> Crawl	<input type="checkbox"/>										
<input type="checkbox"/> Reach	<input type="checkbox"/>										
<input type="checkbox"/> right hand	<input type="checkbox"/>										
<input type="checkbox"/> left hand	<input type="checkbox"/>										
<input type="checkbox"/> overhead	<input type="checkbox"/>										
<input type="checkbox"/> Grasp	<input type="checkbox"/>										
<input type="checkbox"/> right hand	<input type="checkbox"/>										
<input type="checkbox"/> left hand	<input type="checkbox"/>										
<input type="checkbox"/> Fine Manipulation	<input type="checkbox"/>										
<input type="checkbox"/> right hand	<input type="checkbox"/>										
<input type="checkbox"/> left hand	<input type="checkbox"/>										

<input type="checkbox"/> Use Keyboard	<input type="checkbox"/>										
<input type="checkbox"/> Push/Pull	<input type="checkbox"/>										
<input type="checkbox"/> right hand	<input type="checkbox"/>										
<input type="checkbox"/> left hand	<input type="checkbox"/>										
<input type="checkbox"/> Lift ____ lbs	<input type="checkbox"/>										
<input type="checkbox"/> Carry ____ lbs	<input type="checkbox"/>										

Number of hours able to work per day if less than full time _____

Is employee restricted by environmental factors, such as heat/cold, dust, dampness, heights, chemicals, fumes, gases, odors, noise, vibration, etc.?
 No Yes, please explain _____

Other instructions/restrictions/comments _____

 Provider Signature

 Date

Provider Name (print), Address and Phone #:

Temporary Modified Light-Duty Agreement Form

Employee's Name _____ EMPLID _____

Job Title _____

Date and Description of Injury _____

Full-time ____ Part Time ____ Shift/Days Off _____

Department/Location: _____

Temporary Modified Light-Duty Assignment Start Date: _____

Temporary Modified Light-Duty Assignment End Date (max 90 days): _____

Restrictions identified by medical provider include:

Modified Job Duties are:

Supervisor Statement: I have modified this assignment based on the treating physician's medical restrictions.

Supervisor Signature/Date

Employee: I have read and understand this temporary modified/light-duty assignment. By my signature, I acknowledge that this temporary assignment reflects the restrictions indicated by my treating physician. I understand this assignment is temporary and that the College reserves the right to end the Agreement at any time for any reason.

Employee Signature/Date