TRANSITIONAL DUTY TRACKING FORM

Employee Name (print):	Employee's Job Title:
Supervisor Name (print):	HR Generalist Name (print):

☐ Medical provider completed medical status form

☐ Current restrictions have been reviewed

Duties Employee is Unable to Perform:	**Transitional Duties or Modifications to Job or Schedule:**

*I understand that I am engaging in the "Early Return to Work Transitional Duty Program" to request **a.)** transitional duties and/or **b.)** modifications to my job duties or work schedule for the **temporary** physical restrictions identified by my medical provider. I agree to abide by all restrictions as outlined by my medical provider and to inform my supervisor immediately of any changes to my restrictions. I agree to provide medical status updates to my supervisor. I also agree to inform my Human Resource Generalist immediately upon learning that my restrictions are permanent or that I require a leave of absence related to my condition/restrictions. I **understand that transitional duties, job duty modifications, and schedule modifications are temporary** and will only be available to me if the duties I perform are meaningful and productive for both myself and the department.*

Employee Signature:	Date:

To be completed by the Supervisor and HR Generalist

I understand the above-mentioned employee has medical restrictions and is limited in performing one or more of the essential functions of the position. I understand it is my responsibility to provide oversight to ensure this employee does not operate outside of the scope of said restrictions. It is also my responsibility to communicate medical status changes and any related absences to my HR Generalist.

Supervisor Signature:	Date:
HR Generalist Signature:	Date:

Next Health Care Provider Appointment:

(800) 287-8266 TTY (406) 444-1421 WCMB@mt.gov workerscomp.mt.gov

Form Updated September 10, 2024