COUNTY OF TUOLUMNE
MEDICAL WORK RESTRICTION AGREEMENT

Medical Work Restriction for:_____
Date Modified Duty Begins:_____

Your doctor has placed the following medical work restriction on your activities:
_____ No Lifting _____
_____ No frequent bending or stooping.
_____ No sitting over _____ hours.
_____ No standing over _____hours.
_____ No walking _____
_____ Keyboarding allowed _____ hours.
_____ Other

The above restriction(s) are:

_____ Temporary until:

_____ Temporary until removed by:_____

_____ Permanent

Next doctor appointment: Date_____ Time:_____

The physician or health care provider must fill out a work status form each time the employee seeks medical attention as a result of the work related injury. The work status form must be submitted to the supervisor and forwarded to the Human Resources/Risk Management Division.

I, the undersigned, have been advised that medical restrictions have been placed on my activities while performing duties within the scope of my employment. I understand that it is my responsibility not to violate these restrictions. I further understand and agree that if a supervisor requests and I perform duties that would violate these restrictions, I will immediately advise that supervisor and other management staff, if necessary, of my restrictions. I further agree to keep my scheduled doctor appointments and keep my supervisor informed in the event my physician or health care provider changes these restrictions.

_____	_____	_____
Signature of Employee	Date	Phone
_____	_____	_____
Signature of Supervisor	Date	Phone
_____	_____	_____
Risk Management Analyst	Date	Phone