TRANSITIONAL ASSIGNMENT

To:

From:

Date:

Re: Transitional Work Assignment

The has a Return to Work (RTW) program designed to help an employee reach full recovery following an occupational injury/illness. By completing this form the department may assist the employee in finding a temporary transitional assignment that matches his/her current work capability.

Please fill out only what is applicable and return form to the employee or Fax to the number below. If you have any questions regarding the transitional assignment or additional RTW program questions, please contact the RTW Program @ . Fax the completed form to .

1. Positioning: Indicate which of the following should be *avoided* in each area:

☐ Prolonged Standing ☐ Bending ☐ Twisting ☐ Reaching Overhead
☐ Walking ☐ Prolonged sitting ☐ Leaning Forward ☐ Crawling
☐ Climbing ☐ Squatting

Other _____

2. Material Handling: Please indicate which of the following should be *avoided*:

☐ Lifting over 10 lbs. ☐ Lifting over 25 lbs ☐ Lifting objects over 50 lbs
☐ Carrying Object ☐ Lifting object off floor ☐ Check Box
☐ Lifting objects off floor ☐ Lifting objects above shoulders ☐ Check Box
☐ Pulling objects

Other: _____

3. Repetitive Motion: Please indicate which of the following activities should be *avoided*:

☐ Keyboarding Other: _____

4. Time Limitation: for temporary transitional assignment:

_____ Number of hours/per day _____ Number of days/per week

Estimate the length of temporary transitional assignment:

☐ 1-5 days ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ 5 weeks
☐ 6 weeks ☐ greater than 6 weeks

Date of next visit:

Date temporary transitional assignment can begin: _____

Date estimated to return to regular activities: _____

Program is **not** appropriate at this time because: _____

_____

_____

Physician Approval: Date: