Workers' Compensation
Transitional Employment Plan

Employee Name	Organizational Entity
Job Title	Supervisor Reviewing Manager

Physical Capacities/Restrictions	
Date Restrictions Began	Next Review Date

Plan Specifications

Start Date	End Date
Describe job and/or specific tasks:	
Describe hours/day and days/week, including progression schedule:	
Special considerations:	

This Transitional Employment Plan has been reviewed and discussed with me to clarify any questions I may have. I have been provided with a copy of this plan and I understand my supervisor will retain a copy. Should I experience any difficulties while performing transitional work, I will immediately contact my supervisor.

Employee Signature	Date

I have reviewed and discussed this Transitional Employment Plan with the employee. In addition, I have provided a copy of the plan to the employee.

Supervisor or Reviewing Manager Signature Other Transitional Team Members in Attendance Physician's Signature:	Date

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