Modified Work Agreement

Employee Acknowledgement

I, _____, understand and agree to work within the limits as prescribed by the treating physician listed below.

Medical provider: _____

The following work activities are approved by the Medial Provider are specifically aimed to ensure that I do no re-injure and/or aggravate my existing work related injury.

I understand that failure by me to work within these guidelines my result in disciplinary action.

_____ _____

Employee signature *Date*

The supervisors' signature below indicates that he/she has read the above modified work activities and understands that any work tasks they assign to the employee are within these guidelines.

Supervisor name (print) *Signature* *Date*

Follow-up appointments with the medical provider are scheduled for the following dates:

Provider	**Date**	**Time**
Provider	**Date**	**Time**
Provider	**Date**	**Time**