TRANSITIONAL EMPLOYMENT REFERRAL

EMPLOYEE NAME: _____

ID#: _____

TODAY'S DATE: _____ DATE OF INJURY/ILLNESS: _____

EMPLOYEE'S DEPARTMENT: _____

JOB TITLE: _____

EMPLOYEE'S STATUS: □ **OFF WORK** □ **RELEASED TO RESTRICTED DUTY**

NATURE OF INJURY/ILLNESS

☐ Work-Related ☐ Not Work-Related

Describe Injury:

_____

_____

_____

_____

WORK RESTRICTIONS

☐ RESTRICTION FORM ATTACHED

Describe Injury:

_____

_____

_____

_____

Worker's Comp Coordinator/Supervisor Name: _____

Telephone: _____