

CSUSM TRANSITIONAL EMPLOYMENT PLAN

EMPLOYEE NAME: _____	
ID#: _____	EMPLOYEE'S DEPARTMENT: _____
JOB TITLE: _____	SUPERVISOR: _____

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 (TEP) has been reviewed and discussed with me to clarify any questions that I may have regarding the TEP schedule, my responsibilities, and the CSU's responsibilities. I understand that both my supervisor and I will retain a copy of this Plan for our reference. If I should experience any difficulties while performing transitional work, as outlined in this Plan, I will immediately notify my supervisor.

Employee Signature: _____ Date: _____

I have reviewed and discussed this TEP with the employee. In addition, I have provided a copy of the plan to the employee. The original TEP will be maintained in the Office of Safety, Risk Management and Information Security.

MPP Signature: _____ MPP Name (Print): _____

Date: _____

Risk Manager Signature: _____ Date: _____