DATE

MEMORANDUM FOR (Name of Tech)

SUBJECT: \_\_(Name of Tech)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Temporary Light Duty Assignment

Reference:

1. NGB-J1-TN Policy TN-11-02, Subject: Policy for Placing Technician on Light Duty
2. DOD 6055.05-M Occupational Medical Examinations and Surveillance Manual

Based on information you provided in the context of technician physical limitations as prescribed by your attending physician, you are assigned to perform modified duties with the following limitations and restrictions-

1. Light duty such as desk work only
2. You should not lift more than \_\_\_\_\_ pounds.
3. Ability to wear clothing to accommodate wearing of a medical rehabilitation device.
4. Etc.

The modified duties are within your position description functionality and within the limits of the prescribed physical limitations.

(If applicable) You will be temporarily assigned in an alternate work position to the (Name of office, shop or sub-directorate) under the interim supervision (Name of Interim Supervisor). The temp attachment includes administrative accountability and applicable duties as assigned.

This temporary duty is effective on (date).

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Supervisor’s Signature (If Applicable) Interim Supervisor Signature

EMPLOYEE ACKOWLEDGEMENT:

I was in the following duty status when this injury occurred: (Circle one) Technician/Non-Duty Hrs/Military

I accept the above assignment and will adhere to my restrictions and observe safe work practices until I am cleared for full duty by the medical provider in writing.

I understand that maintaining my rehabilitation appointments is my primary responsibility in returning to full duty or maximum functional capacity.

I will provide the IDARNG through either my immediate supervisor or the State Occupational Health Nurse, updated medical documentation specifying continued limited duty or clearance for full performance of duties as written by my attending physician. I will submit updated documentation every 30 days or sooner, as applicable.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

cc: Injury Compensation Program Administrator