UCF Human Resources

Workers' Compensation
Return-to-Work Plan

Part A: To be completed by Employee's Home Department	
Employee Name_____ Employee ID#	Department_____ Division or College
Position Title_____ Attach Copy of Position Description	Supervisor_____ Extension
Medical Restrictions: (Attach a copy of most recent DWC-25 signed by doctor)	

Start Date	End Date
Describe Essential Job Duties the employee cannot perform: (Attach additional sheet if necessary)	
The above named employee has been temporarily reassigned to:	
Current Supervisor_____	Date_____
Signature Dean/Director _____ Print Name _____	Ext._____

Alternate Duty Assignment

Part B: To be completed by temporary department if applicable	
Temporary Department:	
Alternate Duty Supervisor:	Extension:

Modified/Alternate Job Duties

Part C: List below all Alternate Job Duties: (Attach additional sheet if necessary)	
Signature Dean/Director _____ Print Name _____	Ext. _____

Part D: To be completed by Employee and Supervisors
I have reviewed and discussed the above Alternate Duty Assignment with my supervisor and I have been provided a copy of my job description and alternate duties. Should I be unable to attend a scheduled shift, or experience any difficulties while performing the work provided in the Return-To-Work Plan, I will contact my alternate duty supervisor immediately. Employee Signature_____Date_____
I have reviewed and discussed the Return-To-Work Plan with the employee. A copy of this plan has been provided to the employee. Current Supervisor_____Date_____ Alternate Duty Supervisor_____Date_____
Report to: _____ (Supervisor) (Location) (Date) (Time)

Once completed, forward a copy to Human Resources.

Revised 08/2011