TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Offer of Temporary Alternate or Modified Duty Assignment

EMPLOYEE INFORMATION	
Name:	**SSN:**
Mailing Address:	**Date of Injury:** (MM/DD/YYYY)
City, State, and Zip Code:	

The Texas Department of Criminal Justice is in receipt of your Authorization to Release Medical Information and Return to Work Status Form indicating you have been released to perform a temporary alternate or modified duty assignment. The TDCJ is offering you a temporary alternate or modified duty assignment as described on the second page. This assignment shall abide by the temporary physical or mental limitations set out on the **attached** DWC FORM-73, Texas Workers' Compensation Work Status Report or health care provider's statement. **Human resources representatives shall attach one of these documents.**

1. Indicate whether you accept or reject the temporary alternate or modified duty assignment on the second page of this form and return both pages of this form to the human resources representative within three workdays of receipt of this form.
2. If you choose to reject the temporary alternate or modified duty assignment: (1) indicate your rejection on the second page of this form; and (2) within three workdays of receipt of this form, return both pages of this form to the human resources representative.
1. Failure to respond to this offer within the specified time frame shall be considered an official rejection. The State Office of Risk Management may reduce your future workers' compensation benefits.

If you have any questions regarding the temporary alternate or modified duty assignment, job modifications, accommodations, leave entitlements, benefits, etc., contact your human resources representative.

HUMAN RESOURCES REPRESENTATIVE: **Unit or Department:** _____

Printed Name: _____ **Telephone No.:** (_____) _____

Signature: _____ **Date:** _____

FOR STATE AGENCY USE ONLY

Initial verbal offer made ☐ by phone ☐ in person on _____ (MM/DD/YYYY) . Verbal offer was ☐ accepted ☐ rejected (check one).

Offer sent to employee via certified mail on _____ (MM/DD/YYYY) Certified Mail Receipt No.: _____

Temporary alternate or modified duty assignment begins: _____ (MM/DD/YYYY)

Projected expiration date (end of maximum 12 consecutive work week period): _____ (MM/DD/YYYY)

Employee acknowledgement of temporary alternate or modified duty assignment period: _____ Employee Signature _____ Date (MM/DD/YYYY)

Temporary alternate or modified duty assignment expired: _____ (MM/DD/YYYY)

Reason assignment expired: ☐ End of Maximum 12 Consecutive Work Week Period
☐ Other: _____

Employee acknowledgement of expiration of assignment: _____ Employee Signature _____ Date (MM/DD/YYYY)

Temporary Alternate or Modified Duty Assignment Description

EMPLOYEE INFORMATION		
Name:	**SSN:**	**Date of Injury:** (MM/DD/YYYY)
A. Location	**B. Schedule**	
Unit or Department:	**Work Schedule:**	**Card Schedule:**
Address:	**Work Hours: to**	**Hours Per Week :**
	Assignment to Begin:	
Approximate Miles from Employee's Residence:	**Projected Expiration Date:**	
C. Wages		
$ Monthly	**Your rate of pay shall be the same as your current pay rate.**	

D. Duties or Tasks: You shall only be assigned tasks consistent with your physical abilities, knowledge, and skills. Training shall be provided, if necessary.

_____

_____

_____

E. Maximum Physical Requirements: The following identifies the maximum physical requirements for this assignment.

Maximum Hours per day:	0	2	4	6	8	Other
Heavy lifting, 45 lbs & over	☐	☐	☐	☐	☐	_____
Moderate lifting, 15-44 lbs	☐	☐	☐	☐	☐	_____
Light lifting, under 15 lbs	☐	☐	☐	☐	☐	_____
Heavy carrying, 45 lbs & over	☐	☐	☐	☐	☐	_____
Moderate carrying, 15-44 lbs	☐	☐	☐	☐	☐	_____
Light carrying, under 15 lbs	☐	☐	☐	☐	☐	_____
Straight pulling	☐	☐	☐	☐	☐	_____
Pulling hand over hand	☐	☐	☐	☐	☐	_____
Repeated bending	☐	☐	☐	☐	☐	_____
Reaching above shoulder	☐	☐	☐	☐	☐	_____
Simple grasping	☐	☐	☐	☐	☐	_____
Dual simultaneous grasping	☐	☐	☐	☐	☐	_____
Walking	☐	☐	☐	☐	☐	_____
Standing	☐	☐	☐	☐	☐	_____

Maximum Hours per day:	0	2	4	6	8	Other
Sitting	☐	☐	☐	☐	☐	_____
Crawling	☐	☐	☐	☐	☐	_____
Twisting	☐	☐	☐	☐	☐	_____
Kneeling	☐	☐	☐	☐	☐	_____
Pushing	☐	☐	☐	☐	☐	_____
Stooping	☐	☐	☐	☐	☐	_____
Climbing stairs	☐	☐	☐	☐	☐	_____
Climbing ladders	☐	☐	☐	☐	☐	_____
Use of firearm	☐	☐	☐	☐	☐	_____
Oper. motor equipment	☐	☐	☐	☐	☐	_____
Oper. motor vehicle	☐	☐	☐	☐	☐	_____
Other (Explain below)	☐	☐	☐	☐	☐	_____

_____

_____

☐ I am voluntarily **accepting** the temporary alternate or modified duty assignment offered through the Return to Work Program as described above ***for a maximum period of 12 consecutive work weeks***. I fully understand the effect of accepting this assignment.

☐ I am **rejecting** the temporary duty assignment offered through the Return to Work Program as described above. I understand that as a result of rejecting the assignment, SORM may reduce my future workers' compensation benefits.
Reason for offer rejection: _____

_____ _____

Employee's Signature Date (MM/DD/YYYY)

Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023, to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.

Distribution:
ORIGINAL - Unit or Department Employee Medical File
COPY - Employee's Supervisor
COPY - Workers' Compensation Program Area, Human Resources Division
FAX – State Office of Risk Management