UC San Diego
Risk Management

TEMPORARY JOB ACCOMMODATION INTERACTIVE PROCESS

The intent of this document is to assist the employee by identifying light duty work, if possible. Also to comply with applicable State and Federal Laws, University of California Policy and to save the University funds.

EMPLOYEE'S NAME: ____________________

JOB TITLE: ____________________

DATE OF CURRENT WORK RESTRICTION(S): ____________________

1. MEETING PARTICIPANTS AND TITLES:

NAME: ____________________

NAME: ____________________

NAME: ____________________

NAME: ____________________

2. EMPLOYEE WORK RESTRICTION(S) AND SOURCE:

THIS WORK RESTRICTION IS TEMPORARY. THESE WORK RESTRICTIONS ARE TEMPORARY.

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3. EMPLOYEE'S REQUEST(S)/IDEA(S)FOR ACCOMMODATION(S) TO BE CONSIDERED:

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4. ACCOMMODATION SUGGESTIONS BY OTHER(S) (LIST NAME(S)):

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5. AGREED UPON TEMPORARY ACCOMMODATION(S):

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6. SUPERVISOR'S EXPLANATION(S) OF WHY A REQUESTING ACCOMMODATION CANNOT BE PROVIDED AT THIS TIME:

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This temporary job accommodation will be effective immediately and will continue for up to three months unless your status changes, your work restrictions are lifted earlier or the department is unable to provide an appropriate position in accordance with your work restrictions. All medical status updates must be provided in a timely manner to the injured workers' supervisor.

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Employee Printed Name | Signature | Date

____
Department Representative | Signature | Date

____
WC Disability Manager | Signature | Date

____
WC Disability Coordinator | Signature | Date

____
Department Human Resource Representative | Signature | Date