UCF | Human Resources

UNIVERSITY OF CENTRAL FLORIDA

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 employee has been temporarily reassigned to:

Current Supervisor Date

Signature Dean/Director _____ Ext._____

Print Name _____

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 _____ Ext. _____

Print Name _____

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 at loaandworkcomp@ucf.edu.