

**PIEDMONT VIRGINIA COMMUNITY COLLEGE**

**OFFICE OF HUMAN RESOURCES**

**TRANSITIONAL WORK PLAN**

Name of Employee: \_\_\_\_\_

Position: \_\_\_\_\_

1. Current Medical restrictions:

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Date Restrictions Begin: \_\_\_\_\_ Date Restrictions End: \_\_\_\_\_

2. Specific allowable duties:

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3. Specific Limitations:

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4. Schedule of Hours (show progression if appropriate):

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5. Physician Evaluation and Comments:

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I have reviewed this plan and I approve \_\_\_\_\_ disapprove \_\_\_\_\_ it for this patient.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have reviewed this plan and I understand that any modifications will require review by the physician and employee.

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I have reviewed this plan and I understand that any difficulties I might experience should be discussed with my supervisor and/or brought to the attention of the college Human Resources Officer.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_