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| **CHAPTER:** | **5 - EMPLOYEE BENEFITS** | **ADOPTED: 3/7/06** |
| **SECTION:** | **7 – LIGHT DUTY** | **REVISED: 5/22/24** |

## EXHIBIT A – LIGHT DUTY AGREEMENT (Work Related Injuries)

**IT IS THE RESPONISIBITLITY OF THE EMPLOYEE TO SIGN ALL NOTES FOR EACH AND EVERY VISIT TO A MEDICAL PROVIDER AND TO NOTIFY HIS/HER DEPARTMENT OF WORK STATUS IMMEDIATELY AFTER EACH DOCTOR'S VISIT.**

Employee: _____ Date: _____

Department (Regular): _____
Department (Light Duty): _____

***I have been advised that my physical activities at work have been restricted.***

DURATION OF RESTRICTION: _____
DATE TO BE RE-EVALUATED: _____

I understand that my limitations are as detailed on the attached form that has been completed by the Authorized Treating Physician.

By co-signing this agreement with me, my Department Head/Supervisor acknowledges this restriction and is able to accommodate my limitations or provide alternative work for me while I am on light duty.

I acknowledge that it is my personal responsibility to maintain my light duty status for as long as it is in effect. Therefore, if I am asked to perform a task, which is outside of the limits as outlined above, I should not perform that task and immediately notify my Supervisor and Department Head to intervene.

I further acknowledge that should I perform activities outside my limitations, I will be subject to disciplinary action.

_____ _____
***Employee*** ***Date*** ***Department Head/Supervisor (Regular)*** ***Date***

_____ _____
***County Administrator/Designee*** ***Date*** ***Department Head/Supervisor (Light Duty)*** ***Date***

## Light Duty Refusal

I refuse light duty. My rights and benefits have been explained to me, and I understand my worker's compensation temporary disability benefits may be terminated.

_____ _____

*Employee Date* *Department Head/Supervisor Date*