U.S. Department of Transportation
Maritime Administration

MODIFIED DUTY PROGRAM
WORK RESTRICTION FORM

Name of Employee:

The following work restrictions were set by your doctor for your _____ (type of injury) _____.

You must refrain from doing any jobs or duties which require you to perform any of the below listed restrictions.

List exact restrictions here:

_____

_____

These are examples:

- Standing more than 20 minutes at a time
- Sitting more than 20 minutes at a time
- Walking more than 20 minutes at a time
- Lifting 11 - 25 lbs. more than occasionally
- Lifting over 26 lbs.
- Bending, squatting, kneeling, climbing more than intermittently

These restrictions are in effect from _____ (date) through _____ (date) unless otherwise indicated by documentation from your doctor.

You are responsible for notifying your supervisor and the agency representative who handles your workers' compensation claim of every doctor's appointment (including physical therapy appointments, etc.) that you have.

This document is merely to put these restrictions in writing so that you understand the restrictions, as well as for your immediate supervisor to know the medical restrictions you are under. This will also serve as information for any supervisor you work under on a particular project.

Please sign below as an acknowledgment that you understand the medical restrictions you must work under. A copy of the form will be given to you.

_____ _____
Employee's Signature Date

_____ _____
Immediate Supervisor's Signature Date

_____ _____
Second-line Supervisor's Signature Date

_____ _____
Safety Officer's Signature Date

_____ _____
Workers' Compensation Representative's Signature Date

*[**NOTE:** "Occasionally" = up to 1/3 work day; "Intermittently" = up to 1/3 - 2/3 of work day; "Frequently" = more than 2/3 of work day but not a full day]*