

AGREEMENT TO RESTRICTIONS

Name of Employee: _____

Employee ID Number: _____

Facility/District/Unit: _____

1. Your return to work is conditioned upon your complying with the physical restrictions indicated by the authorized treatment provider and listed in the attached report.
2. If your provider ordered an ergonomic evaluation, your work status is conditioned upon compliance with the recommendations arising from the ergonomic evaluation.
3. These restrictions are in effect until _____
4. Failure to abide by these restrictions will subject you to disciplinary action, up to and including termination.

Signature of Employee

Date

Signature of Supervisor

Date