<NON-OCCUPATIONAL INJURY/ILLNESS TRANSITIONAL DUTY ASSIGNMENT TEMPLATE>

**DATE:**

**TO:**

**FROM:**

**SUBJECT:** TEMPORARY TRANSITIONAL DUTY ASSIGNMENT

We are pleased to inform you that we have a temporary transitional duty (TTrD) assignment available based upon the temporary restrictions stated in your physician’s letter, dated <***INSERT DATE***>. The work restrictions are **<*INSERT DESCRIPTION OF RESTRICTIONS*>**. The duration of this transitional duty assignment is <***INSERT NUMBER OF DAYS***>, beginning **<*INSERT DATE*>** and ending **<*INSERT DATE***>. At the end of this assignment, you will have worked a total of **<*INSERT NUMBER*>** TTrD days.

Your transitional duty assignment will include the following tasks and responsibilities:

**<*INSERT DESCRIPTION OF THE TRANSITIONAL DUTY ASSIGNMENT*>**

In addition to the transitional duties listed above, you may be asked to perform other duties that meet your restrictions and fall within the scope of your job classification.

Any change to your work restrictions requires revised medical documentation, as a different temporary transitional duty assignment may need to be considered.

The intention of the TTrD program is to assist injured employees to regain their ability to return to their regular work assignments during a defined period of time. The Policy defines Transitional Duty as selected assignments that take employees in stages from tasks they can perform within medical work restrictions to performing their regular job duties.

***<FOR REPRESENTED EMPLOYEES ONLY>*** If your MOU requires a 7-day schedule change notice, this letter serves as the notice for both your temporary transitional duty assignment and returning to full duty on your original work schedule. ***<FOR REPRESENTED EMPLOYEES ONLY>***

Extensions of temporary transitional duty assignments may be granted with appropriate medical documentation. An extension beyond 90 days may be granted with Department Head approval. In no event shall a temporary transitional duty assignment be allowed beyond 180 days for non-occupational injuries, pursuant to the County’s Temporary Transitional Duty Policy.

If you feel you have any further work restrictions, please let me know and I will provide you with an Essential Functions Worksheet (EFW) or a Job Demand Analysis (JDA). Your doctor will need to review the EFW and provide the Department with a medical certification outlining any further restrictions. For each restriction, we need to know if there is some portion of the function that you can perform. For any portion that you cannot perform, we will need to know if the restrictions are temporary or permanent and if temporary, their anticipated duration.

More information and copies of the Medical Leave Policy, Disability and Reasonable Accommodation Policy, and the Temporary Transitional Duty Policy, can be found at:

<https://sonomacounty.ca.gov/CAO/Administrative-Policies/Medical-Leave-Policy/>

Please be advised, that not participating with the duties assigned in a temporary transitional duty assignment may result in the loss of long-term disability benefits. Please contact your supervisor immediately if you are unable to perform the assigned job duties.

***<ONLY IF APPLICABLE>*** The location of the temporary transitional duty assignment is <***INSERT ADDRESS/LOCATION***>. During this transitional duty assignment your supervisor will be <***INSERT NAME***>.***<ONLY IF APPLICABLE>***

Please contact me with any questions you may have.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Employee Employee Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Supervisor Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Department Designee Department Designee Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Department Head Signature Date

(For approvals over 90 days)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Human Resources Director Signature Date

(For approvals over 180 days)

**cc: *<NAME, Disability Management Analyst>***

Confidential Medical File