City and County of San Francisco
Carol Isen
Human Resources Director

Department of Human Resources
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Temporary Transitional Work Assignment Agreement

This form must be used to document all Temporary Transitional Work (TTWA, also commonly known as "modified duty"), performed by an employee who is recovering from a **work injury or illness** but may safely perform modified work activities prescribed by their treating physician prior to their release to full duty or pending a determination of any permanent work restrictions.

Assignments in the Temporary Transitional Work Program may be made for a period lasting up to 90 calendar days. Additional increments to allow additional work assignments may be approved for a combined maximum period of 180 calendar days consistent with the employee's health care provider's documented reduction in work restrictions. Such changes must be documented in a revised TTWA form.

Employee Name	**Workers' Compensation Claim #**	**Department/Division/Unit**

Work Restrictions: (ex: no lifting over 50 lbs, no keyboarding for more than 2 hours w/out a break, as listed on the physician's Work Status Report)

Description of Assignment:

Date Assignment Begins:	**Date Assignment Ends:**

Employee Responsibilities	**Supervisor Responsibilities**
• Work within the physical limitations set by the doctor. • Let the supervisor know if you are having difficulties with any of your assigned tasks. • Inform the supervisor if you must leave work for medical appointments. • Immediately provide your **supervisor** and assigned **claims adjuster** with any changes in restrictions on the Work Status Report from the doctor.	• Communicate regularly with the employee regarding his/her progress. • Monitor changes in restrictions and assign new duties as appropriate and available. • Monitor the employee's work for compliance with the physical limitations set by the doctor. • Keep a copy for your records. The department TTWA coordinator will distribute to the assigned workers' compensation claims adjuster. • Do not allow the employee to work beyond the date the assignment ends.

Supervisor Name	**Supervisor Contact**	**Date Offer Provided to Employee**

Employee Acceptance/Declination (Check one)

☐ I have read, fully understand, and agree to the duties, responsibilities, and limits of this assignment.

☐ I am declining this temporary assignment and understand that by doing so I may no longer be entitled to temporary disability benefits (or disability pay for public safety officers).

Employee Signature	**Date**

Department Representative Name & Signature	**Date**