

**ATTACHMENT C**  
**LIGHT DUTY REPORT {PRIVATE }**

EMPLOYEE \_\_\_\_\_

PHYSICAL/PSYCHOLOGICAL RESTRICTIONS:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TYPE OF LIGHT DUTY: \_\_\_\_\_

LOCATION OF LIGHT DUTY: \_\_\_\_\_

SUPERVISOR OF LIGHT DUTY: \_\_\_\_\_

DURATION: \_\_\_\_\_ START DATE \_\_\_\_\_ END DATE \_\_\_\_\_

NO. OF HOURS PER WEEK: \_\_\_\_\_

DUTIES AND RESPONSIBILITIES:  
\_\_\_\_\_  
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(OVER FOR ADDITIONAL DUTIES & RESPONSIBILITIES)

Supervisor's Approval: \_\_\_\_\_  
Signature Date

Treating Physician's Approval: \_\_\_\_\_  
Signature Date