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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(OVER FOR ADDITIONAL DUTIES & RESPONSIBILITIES)

Supervisor's Approval: _____
Signature Date

Treating Physician's Approval: _____
Signature Date