CAL STATE FULLERTON
TRANSITIONAL WORK PLAN

Employee Name: Department:		Date WC Date of Injury (if applicable)
Manager/Chair	Regular Job Title	Class code

Physical Capacities/Restrictions	
Date Restrictions Began	Next Review Date
Plan Specifications	
Start Date	End Date **(Completed by WC/ Disability Manager only)**
Describe job and/or specific tasks:	
Describe hours/day and days/week, including progression schedule:	
Special considerations: This Transitional work assignment is contingent upon the following:	
• Continuing review by your physician. • Your adherence to the work restrictions prescribed.	
• Satisfactory performance of the duties assigned. • Continuing need for the work assigned.	
TRANSITIONAL WORK IS TEMPORARY AND IS INTENDED TO HELP YOU RETURN TO WORK AND TO YOUR PERMANENT WORK ASSIGNMENT. THIS IS NOT A PERMANENT ASSIGNMENT.	

This Transitional Work Plan has been reviewed and discussed with me to clarify any questions I may have. I have been provided with a copy of this plan and I understand my supervisor will retain a copy. Should I experience any difficulties while performing transitional work, I will immediately contact my supervisor.	
Employee Signature	Date

I have reviewed and discussed this Transitional Work Plan with the employee. In addition, I have provided a copy of the plan to the employee.	
Manager's Signature	Date
WC/Disability Accommodations Manager's Signature	Date