# Baldwin County Personnel Department
## Acknowledgement of Temporary Transitional Duty Assignment

I have been advised of the physical limitations outlined by the attending physician/medical provider and understand my work restrictions. I further understand that it is my responsibility not to violate these restrictions without specific medical authorization. I further agree that if management asks that I perform duties, which would violate these work restrictions, I will immediately advise my assigned supervisor and/or other management, if necessary, of my physical limitations concerning the requested duties. I understand that these accommodations are temporary and that they may be canceled at any time by the Baldwin County Commission or their designated representative.

**I HAVE RECEIVED A COPY OF THE TRANSITIONAL DUTY POLICY, AND AS A PARTICIPANT IN THIS PROGRAM, I WILL ADHERE TO ALL POLICIES AND PROCEDURES.**

**Restrictions:**

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This is in effect until the next doctor's appointment on: _____

_____ _____

Injured Employee Signature / Date Print Injured Employee Name

_____

Direct Supervisor Signature / Date

_____

Safety Coordinator Signature/ Date

_____

Risk Manager Signature / Date

_____

Personnel Director Signature / Date

_____

Appointed Dept. Director Signature / Date