



# Modified Duty Assignment Form

Safety & Emergency Management

Frederick County Public Schools

191 South East Street

Frederick, Maryland 21701

Form 175-F09

May 2026

Clear Form

Submit completed forms to: [workers.comp@fcps.org](mailto:workers.comp@fcps.org)

## EMPLOYEE INFORMATION & INCIDENT DATA

Employee Name: _____	Job Title: _____
Supervisor Name: _____	Work Location: _____
Date of Injury: _____	Claim Number (if known): _____

## MEDICAL RECOMMENDATION: [From the attending physician's Work Status Report]

Primary Restriction(s):

Anticipated Duration: From [Date] \_\_\_\_\_ to [Date] \_\_\_\_\_

## ACCOMMODATION DETERMINATION: [Completed by the immediate supervisor through the interactive discussion process with the employee]

Based on the interactive process, the following accommodations have been identified:

<input type="checkbox"/> Environmental Change:	<input type="checkbox"/> Modified Duties:
<input type="checkbox"/> Equipment/ADR:	<input type="checkbox"/> Schedule Adjustment:

## ATTESTATION & SIGNATURES

If the temporary transitional duty offer is refused, the employee will not be eligible for further Worker's Compensation Leave and further Temporary Total Disability (TTD) or Temporary Partial Disability (TPD) may be affected. Upon returning to work, all employees are expected to follow Attendance and Leave Request requirements set forth in FCPS Policies and Procedures and the Negotiated Agreement.

**Employee:** I participated in the interactive process with my supervisor. I understand that these accommodations are temporary and designed to allow me to return to work; either performing my regular job duties with accommodation or in a modified duty assignment. I agree to work within my medical restrictions and will notify my supervisor immediately if my medical status changes or if the accommodation is no longer effective.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_  I Accept the modifications  I Reject the modifications

**Supervisor:** I have engaged in a good-faith interactive process with the employee to ensure the employee is offered an opportunity to return to work; either performing their regular job duties with an accommodation or in a modified duty assignment, because of a work-related injury or illness. The intent of this accommodation is to support the employee's successful return to work.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Other Specific Plan Details:**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.