

LIGHT (MODIFIED DUTY) LOG

Department: _____
 Supervisor: _____

Name: _____
 Job Title: _____

DATE	TIME IN	TIME OUT	TASKS PERFORMED
Sunday _ / _ / _	: _	: _	_____

Monday _ / _ / _	: _	: _	_____

Tuesday _ / _ / _	: _	: _	_____

Wednesday _ / _ / _	: _	: _	_____

Thursday _ / _ / _	: _	: _	_____

Friday _ / _ / _	: _	: _	_____

Saturday _ / _ / _	: _	: _	_____

I clearly understand, take responsibility for, and acknowledge the limitations my physician, Dr. _____
 has placed on me while participating in this temporary transitional work program.

 (Employee Signature)

_ / _ / 20__