Rutherford County – Employee Accommodation Plan

Employee Name:	**Employee Title:**
Supervisor:	**Date:**

Restrictions	**Job Related Tasks Impacted**

Attach physician statement.

- ❑ Accommodation cannot be met.
- ❑ Accommodation can be met.

Description of Accommodation Measures

Attach additional pages if necessary.

Accommodation measures will be implemented effective _______________ to _______________.

If there is no end date, the next review of accommodations will occur on ___________________.

Employee acknowledgment: By signing this form, I acknowledge that my restrictions have been explained to me and that I understand that my restrictions apply while I am at work and away from work.

Employee's Signature Date

Supervisor's Signature Date

Please email form and any attachments to safety.oji@rutherfordcountytn.gov or fax to 615-713-3441. The original, along with the doctor's note, should be kept in the employee's file.