

Back to Work Follow-Up Form

Employee name: _____ Date: _____

Supervisor's name: _____ Supervisor's phone #: _____

Chesapeake Employers' Claims Adjuster's Name: _____

Employer's/Company name: _____

Date scheduled to begin transitional duty: _____

	Yes	No
1. Did the employee show up for transitional duty as scheduled? If no, why not?		
2. Has the employee been coming to work regularly? If yes, answer the following questions. If no, answer question 5.		
3. Are there any problems or issues with the transitional duty assignment? If so, what are they?		
4. If there are problems, are they related to medical issues? If yes, what are the specific complaints?		
5. Has the employee been evaluated by his/her physician since the initial assessment? If so, give the date of the last assessment: _____		
6. Does the supervisor need to contact the employee's physician about the nature of the tasks assigned? If so, give the date of contact and result:		
7. Are there any modifications needed in the transitional assignment? If so, what specifically?		
8. Can the employer accommodate these modifications? If yes, how? If no, why not?		
9. What date will the modifications be effective?		
10. Does the employee agree to these changes? Was an offer letter sent?		

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____