**Acknowledgement Form: Refusal to Return to Work**

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| **Employee’s Name:** | **Date of Injury:** |
| **Supervisor’s Name:** | **Date notified the employee should not return to work:** |

The Worker’s Compensation Coordinator in collaboration with the Employee’s Supervisor has determined that the university cannot offer modified or transitional work duties to the injured employee at this time We will continue to work in collaboration with the employee and their treating healthcare provider, to ensure that the employee continues to progress in their healing and will continue to monitor when they will be able to return to work safely in limited or full capacity.

**OR**

The treating healthcare provider has determined the employee may return to work in limited or full capacity and was offered transitional modified work assignments within the university, however, the employee has refused to return to work.

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| Employee’s Signature: | Date: |
| Institution’s Administrator Signature and Title (approved to sign): | Date: |