The University of California, Santa Barbara is committed to achieving a successful recovery and return to work for our ill/injured employees. The Transitional Work Program (TWP) is designed to help employees return to work safely and at the earliest opportunity, using appropriate modified work alternatives when needed.

### EMPLOYEE’S INFORMATION

<table>
<thead>
<tr>
<th>Employee Name (please print)</th>
<th>Date</th>
</tr>
</thead>
</table>

**To be completed by PHYSICIAN/ TREATING PROVIDER:**

**NO diagnostic information please**

This employee may perform:

- **□ Modified Duties**

  - Keyboard: ______ Minutes/ Hour
  - Sit: ______ Minutes/ Hour
  - Stand/ Walk: ______ Minutes/ Hour
  - Climb: ______ Minutes/ Hour
  - Lift/ Carry: ______ LBS Maximum
  - Push/ Pull: ______ LBS Maximum
  - Other, specify:

  - **□ Modified Hours**

    - from: ______ to: ______ with the following schedule:

      - ______ Hours per Day, ______ Days per Week - OR - ______ Hours per Week

  - **□ Not Capable of ANY Work**

  - from: ______ to: ______

  - **□ Full/ Regular Duty**

    - (date)

  - **Next appointment:** ______ (date)

  - **Comments:**

    - ________________________________

    - ________________________________

    - ________________________________

  - **Treating Provider’s Name and Address or Stamp**

  - **Treating Provider’s Signature**

  - Date

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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 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, an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**PLEASE RETURN THE COMPLETED FORM TO YOUR SUPERVISOR AND/OR DEPARTMENT REPRESENTATIVE**