**TEXAS DEPARTMENT OF PUBLIC SAFETY**

**TEXAS HIGHWAY PATROL DIVISION**

**TEMPORARY ACCOMMODATION REQUEST APPROVAL**

Date:

*Employee’s Name*

*Mailing Address*

*City, State and Zip Code*

Re: Temporary Accommodation Request

As a valued employee, your contributions and expertise are an asset to this department. We would like to make every attempt to return you to a temporary duty assignment as soon as possible in order for you to remain a productive member of the Department of Public Safety workforce. The Department has received information from your examining health care provider allowing your return to temporary duty.

Your request for a temporary accommodation has been reviewed and modifications have been approved. Your supervisor has been notified of the accommodation and will work with the chain of command to address any safety issues with your new position. This accommodation will be in place until (*insert date request to expire*). Attached you will find the modified job duties which are outlined by your physician on the Evaluative Medical Status Report (DPS form HR-87) dated (*insert date of examination*).

Your assignment will be in adherence to the attached restrictions outlined by your physician*.* You are expected to report to *(Name of Supervisor and Department)* at *(Address of temporary job)* on *(Time and Date)* for your job assignment. Your schedule will be *(insert days and hours)*.

If you are a commissioned officer during this time of authorized modified duty, you will not be permitted to wear a DPS uniform, drive or ride in a black and white patrol unit or take any type of law enforcement action, on or off duty. You are also restricted from any previously authorized secondary employment during this time. During this time of modified duty Expanded Enforcement Program overtime is not approved.

**You are responsible for obtaining a subsequent HR-87 from your treating health care provider at least once every 30 days if your approved temporary accommodation is for a period of more than 30 days.** Each completed HR-87 shall be provided to your immediate supervisor within 2 working days of your health care provider’s examination and a copy needs to be sent to the THP Return to Work Coordinator.

Modifications or changes for approved temporary accommodations less than 30 days can only be reviewed if an updated HR-87 is completed. If that occurs, please inform your immediate supervisor or the THP Return to Work Coordinator as soon as possible.

Please understand that a temporary approved accommodation is not a permanent placement.

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| Approval Signature Date |

 **ACKNOWLEDGEMENT**

This accommodation has been reviewed and explained to me by the THP Return to Work Coordinator and/or my supervisor. My signature below indicates that I [ ]  accept [ ]  decline this accommodation.

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Employee Signature Date Supervisor/Witness Signature Date