State of Iowa
Department of Administrative Services
Human Resources Enterprise

Alternative Duty Assignment

Employee Information	**Name**	**Injury date**
	Employed by *(State entity)*	**Manager/Supervisor name**
Alternative Duty Information*	**Date alternative duty began**	**Total alternative duty work days completed,** *(prorated to normal work day)*
	Recently performed tasks	
	Proposed tasks	
Medical Information*	**Alleged injury body site(s)**	*(Provide clinical information only)*
	Prior temporary work restrictions	
	Medical treatments to-date	
	Estimated date of Maximum Medical Improvement (MMI)	
	Length of extension requested *(Number of workdays prorated to normal work day. NOTE: Extensions should be no more than 20 workdays.)*	
Person Completing Form	☐ I acknowledge that following DAS approval, an Alternate Duty letter will be sent to the employee.	
	Name	**Email**
	Work phone	**Cell phone**
DAS/HRE Only	☐ **Request Approved** ☐ **Request Denied**	
	DAS/HRE Representative Signature	

Submit to DAS/HRE

*Additional information may be attached and emailed.