**Light Duty - Sample letter 3**

Place on your letterhead

Send regular *and* certified mail

Employee name

Employee address

Re: [Claim #]

Date of injury: [Month][Day][Year]

Dear [Injured Worker Name]:

We sincerely hope that recovery from your work-related injury is progressing satisfactorily.

Your physician has provided physical restriction information to allow you to return to work as soon as possible while still achieving full recovery from your injury. Dr. [Physician Name] has indicated you are able to work with the following limitations:

[Insert physician’s restriction information]

We would like to take this opportunity to extend an offer for your return to work in a capacity that meets the above-noted restrictions. You will be paid your regular salary [hourly rate] regardless of any limitations your doctor has set on hours worked or duties performed. The job involves the following tasks:

[Insert job description information]

These job duties are temporary in nature, and you may transition back to your regular job assignment when your doctor has determined you are capable. The position will have a start date of [insert date.] The job hours will be [specify hours]. You will report to [Supervisor's Name] and the work will be performed at [location]. All [Company Name] policies, including attendance, punctuality and call off procedures, will apply as usual during this transitional work period.

Please notify us of your interest in this position by [date approximately 5 days after mailed to allow for delivery]. A failure to respond will be considered a refusal of this offer of suitable transitional work. You should be aware that refusing to accept work within your physician’s medical restrictions may end your compensation benefits through workers’ compensation.

Your reply and any questions regarding this transitional work offer should be directed to [Employer Workers’ Compensation Coordinator Name] at [phone number]. We look forward to hearing from you and having you back as a member of our team.

Respectfully,

[Signature]

[Title]

This agreement shall be in effect until such time as the physician of record feels that you are physically capable of resuming regular work, and for a period not to exceed [number] days from the date of the agreement.

Check one:

* I accept this transitional work offer. I agree to keep my employer advised of any changes in my physical restrictions and will promptly advise my employer upon release to full duty by my physician.
* I do not accept this transitional work offer. I acknowledge that this refusal may result in denial of my temporary total compensation.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

cc: [Employee's Attorney's Name, if applicable]

Bureau of Workers’ Compensation