

SAMPLE Letter 1

DATE

Employee's Name

Hand-delivered

Subject: Offer of Modified Work Assignment

Dear _____:

Based on medical documentation dated *DATE*, provided by your physician, we currently have a temporary modified work assignment available. This will enable you to return to work in a setting appropriate for your physical capabilities and restrictions.

According to your physician, *Name of Physician*, based on your injury from *Date of Injury*, you may engage in work activities for 8 hours a day that adheres to the following conditions:

- **No lifting more than 10 pounds**
- **Data entry limited to 2 hours at a time**
- **Alternate data entry, filing and other clerical duties**
- **Stretch 1 minute every 30 minutes**
- **Alternate sitting and standing as needed**

Your temporary modified work assignment will include the following modified duties:

- **Data Entry** - Entry of words and numbers from documents into preformatted data screens using Access or similar software. Requires digital/keyboard acuity with repetitive motion of typing and reading documents and data screen for extended periods.
- **Telephone Coverage**- Answer telephones and takes messages or route calls using reference sheet. Task will involve sitting or standing at desk. Description of motion includes use of arms and hands, which can be adapted to headset to reduce grip requirements. Writing will be required for duplicate message books or work tickets.

SAMPLE Letter 1

Employee's Name

Page 2

Date

- **General office tasks** – Combination of telephone answering and message task, with additional functions including mail opening and distribution, filing, data entry, collating, P. O. distribution, and miscellaneous clerical work. Work will be done primarily in a sitting position at a desk. Repetitive manual motions may include typing, opening and closing drawers, standing, reaching and bending. No lifting over 15 pounds is required.

Your work is very much needed and valued in the department. Please report to ***Manager/Supervisor*** in the _____, on ***Date***, to begin your work assignment. This 8-hour per day assignment will continue until you are released to full duty by your physician.

Failure to report to work as stated above will result in a forfeiture of your temporary disability benefits. You are expected to work all available hours and will not be compensated for lost time that has not been approved by your treating physician.

Please contact Human Resources Office at _____, if you have any questions concerning your temporary disability benefits.

Sincerely,

Personnel Analyst