*(Date of letter)*

*(Doctor’s name and address)*

Subject: *(Employee’s name and date of injury)*

Dear Dr *(Doctor’s Name)* :

Our Company has implemented a return to work program designed to return any injured employee to medically appropriate work as soon as possible.

Enclosed is a detailed job description for the regular job of the employee named above, which may be modified, if possible, to meet medical restrictions that may be assigned. If our employee is unable to return to his or her regular job, we will attempt to find an appropriate alternate work assignment. We will ensure that any assignment meets all medical requirements as directed toward your specific treatment strategies. We will consider re-arranging work schedules around medical appointments if necessary. To that end, we request that you complete the enclosed Transitional Assignments Form with as much detail as possible.

If you need additional information about a possible work assignment or about our return to work program, please call *(Return to Work Program Contact name and number)*. Our insurance carrier is *(name and address of insurance carrier)*.

Thank you for your participation in our efforts to return our employees to a safe and productive workplace.

Sincerely,

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*(Signature of company representative or owner) (Title), (Name of Company)*

Encls: Signed authorization

Job descriptions and task analysis Transitional Assignments Form