OFFER OF MODIFIED WORK

Dear [Insert Employee Name]:

[Organization Name]has a formal Return to Work and accommodations program in place in accordance with the requirements of all legislative bodies and insurance providers. This program serves to assist our employees with an early and safe return to work following a work-related injury/illness.

We have an obligation to offer you modified duties based on your functional abilities’ information. You have an equal obligation to cooperate in your timely return to work including having the enclosed Functional Abilities Form (FAF), completed by a healthcare practitioner.

**This letter will serve as confirmation that modified work is being offered to you and is available immediately, based on your functional capabilities. Once your FAF has been completed and returned, suitable modified duties will be assigned.**

You are legally obligated to participate in modified work should you be eligible and in accordance with medical documentation that is provided.

Enclosed are instructions to assist you in your early and safe return to work and the necessary forms that must be completed by you and your doctor. Please return the completed forms to your supervisor following your appointment, prior to your next scheduled shift.

If you have any questions, please contact [Insert Contact].

Sincerely,

[Insert Name]

[Insert Title]

[Insert Contact Information]

Encl: [Insert any forms which must be completed e.g. Functional Abilities Form]