[EMPLOYER LETTERHEAD]
[DATE]

[**CLAIMANT ADDRESS**]

Dear [**CLAIMANT**]:

[**EMPLOYER**] is in receipt of a report dated
from Dr.
relating to
your current medical condition and your ability to work. A copy of that report is enclosed with this letter. [**EMPLOYER**] has used guidelines provided by the physician to identify an appropriate modified duty position for you. [**EMPLOYER**] hereby extends to you a good faith offer of employment.

You will be expected to return to work on or before [**DATE EMPLOYMENT IS TO BEGIN, (RECOMMEND AT LEAST 7 DAYS FROM DATE OF NOTICE)**] at [**ADDRESS AND LOCATION OF EMPLOYMENT, WHICH SHOULD BE GEOGRAPHICALLY ACCESSIBLE TO EMPLOYEE**]. Your work schedule will be as follows: [**DETAIL DAILY/ WEEKLY HOURS OF WORK**]. Your wages will be as follows: [**DETAIL HOURLY/ WEEKLY WAGES OR SALARY**].

This position will entail these specific physical and time requirements: [**SPECIFY IN DETAIL THE PHYSICAL REQUIREMENTS OF THE JOB, THE AMOUNT OF TIME TO BE SPENT DOING EACH, SCHEDULED BREAKS, ETC.**]

Please be assured that [**EMPLOYER**] will only assign you tasks consistent with your physical abilities, knowledge, and skills and will provide you training if necessary.

If you accept this offer, please indicate by signing and dating your name below and returning this to the undersigned. If [**EMPLOYER**] does not receive this back from you within seven (7) days of receipt, [**EMPLOYER**] will assume you have rejected this offer. Please note: refusal of this employment offer will result in termination of any temporary disability benefit fifteen (15) days from the date of this notice.

NAME **DATE**

Please contact the undersigned with any questions you might have.

Sincerely,
[**EMPLOYER**]