SAMPLE

Date:

TIME SENSITIVE
URGENT RESPONSE REQUIRED

[Doctors Name]
[Facility]
[Address]

[Address to employee's designated provider]

FAX to:
Attn:

[Your contact information]

Re:
Claim No.:
Employer:
DOB:

Dear Dr. [Doctors Last Name] :

[Employee's Name] is currently unable to perform the physical tasks required of [his/her] regular job. [Company Name] has temporary modified duty work available which requires the ability to perform the tasks outlined below.

If you have any questions regarding the outlined tasks, please contact [Employer Name], with [Company Name] at [Phone Number].

JOB TASKS

Work Shift: [Indicate number of hours per shift and number of shifts per week]

Please check the tasks that [Employee's Name] is currently able to perform.

List tasks and include physical demands

____ **Compile mailings** — Stuff letters into envelopes, attach labels and stamps, and seal envelopes. Involves sitting, standing, handling and fingering.

____ **Collate booklets or materials** — Put information for booklets, handouts, folders or projects in correct order. Staple, punch holes, collate or bind booklets. Lifting up to 5 pounds. Involves sitting, standing, handling, fingering, reaching and gripping.

[Employee's Name] is able to perform the tasks checked above.

COMMENTS: _____

_____ _____

Doctor's Signature (MD or DO required) Date

_____

Doctor's printed name

Cc: [Employee]
Cc: [Attorney]

[Include the employee's name and address as he/she must also recieve a copy; if the employee is represented, also include attorney's name and address for mailing]