[Date]

[Authorized Treating Physician, Name and Address]

Re: [Claimant's Name] v. [Employer/Insurance Company].
W.C. No.
Carrier No.

Dear Dr. [_____]:

Our employee [Claimant's Name] is currently unable to perform the regular duties of his/her job. [Employer] has identified a modified job position, which appears to be within his/her current restrictions. Please review the job duties and schedule below, and provide your opinion whether [Claimant's Name] is capable of performing the job duties at this time. If you believe that [Claimant's Name] can perform the job duties, please approve the job offer by signing this letter below and immediately return this form to our office. We appreciate your time and expertise spent in addressing this issue.

Work Schedule: [Days Per Week, Hours Per Day]

Detailed Description of Job Duties: [Lifting Requirements, Duties, Specific Responsibilities]

Additional Details and Comments Regarding Job Duties:

I have reviewed the above job offer and it is my opinion that [Claimant's Name] has the physical capacity and ability to perform all of the job duties offered. I am approving this job offer by providing my signature below.

Physician's Signature:_____

Date:_____

cc: [Claimant as required by Rule 6-1(A))(4)]
[Claimant's Attorney as required by Rule 6-1(A)(4)]

[Please note that this form should be attached to the job offer subsequently provided to claimant]