Date: _____

Mr./ Mrs. Ms.: _____

SSN: _____

Date of Injury: _____

Please be advised that modified work is available for you, effective, _____.
Your job responsibilities consist of _____
_____, which will not exceed the
following limitations as prescribed by your doctor:_____
_____.

Therefore, please contact our office at _____, for assignment Instructions and to confirm your acceptance of our job offer. Failure to accept, modified work may affect your Workers' Compensation benefits.

I understand that all regular employment rules and policies apply to modified and alternative light duty positions.

(Acknowledgement of job offer)

| _____ | _____ | _____ |
|---|---|---|
| Employee Signature | Print Name | Date |

| _____ | _____ | _____ |
|---|---|---|
| Employer Representative | Print Name | Date |