

TRANSITIONAL JOB OFFER

Date _____ Employee Name _____

Claim No. _____ Date of Injury _____

Employee address (if mailed)

Dear _____:

Your physician, Dr. _____, has released you for modified work with the following restrictions (or see attached medical form): _____.

Your doctor has approved the following transitional position for you. Since the position is transitional, it will be periodically evaluated. This job is _____.

We ask that you report for work on (date) _____.

Please report to _____ at (time) _____.

If you receive this letter after the report-to-work date listed above, you will have 24 hours to contact: _____

_____ *at* _____.

Failure to report to work could affect your entitlement to temporary disability benefits.

We look forward to seeing you and wish you a speedy recovery.

Sincerely,

Employer Name, Title _____
Date

To be completed upon return to work	
Hours per day/week	Days per week
Duration of job (if known)	Supervisor

You will be receiving \$ _____ per (hour/week/month). If this is less than your regular earnings, you may be entitled to wage loss benefits from your workers' compensation carrier. ***(Kentucky employers: This provision is not offered by Kentucky law.)***

I have read and understand the above information.

Employee Signature/Date _____
Employer Signature/Date

Please bring this form with you when you report to work.