# Form B1: Letter to Physician

Date:

Date of injury:

Employee:

*Re: Return-to-work (RTW) program*

[EMPLOYER] offers a formal RTW program. As part of our program we have modified or alternate duties available for our injured employees.

Your support in defining any temporary restrictions or functional limitations is key and will help us provide the most suitable duties during your patient’s recovery.

After examining [EMPLOYEE], please complete *Form C: Physician Assessment — Return-to-Work Planning* and give it to your patient to return to us. Alternatively, you can fax it today directly to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

If you have any questions or concerns, please contact me at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

If there is a cost associated with completing *Form C*, please send an invoice to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. We will cover fees up to \_\_\_\_\_\_\_\_once the form has been fully completed and returned.

Sincerely,

## Attachments

* Form C: Physician Assessment — Return-to-Work Planning