# Form B2: Letter to Physician — Modified Work

Date:

Date of injury:

Employee:

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

[EMPLOYER] is pleased to support a formal RTW program. As part of this program we have modified or alternate duties available for our injured employees.

We are immediately able to offer [EMPLOYEE] the attached modified work accommodations. **Please see the attached *Form D: Modified Work Offer* that has been provided to [EMPLOYEE].** Please confirm that you have reviewed the attached offer, and indicate whether any task is outside of [EMPLOYEE’S] restrictions or limitations. Also, please complete the attached *Form C: Physician Assessment — Return-to-Work Planning* to further support our understanding of your patient’s needs. At the end of your appointment, return the forms and comments to [EMPLOYEE] or fax your comments to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or email your comments to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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.

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

Sincerely,

## Attachments

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