Sample Cover Letter/instructions for Injured Worker

Company name & address

Contact name & number

Dear Employee,

We are sorry to learn of your injury and your recovery is important to us. (Company Name) is committed to ensuring the safety and health of our employees, and it is important to learn how your injury occurred so preventative measures can be taken in the future.

(Company Name) has a Temporary Transitional duty program to aid in the recovery process following an on-the-job injury. Should your injury require that you work a transitional temporary job during recovery please help us by clearly communicating any injury-related problems you have performing your assigned duties.

Below is a list of what needs to be done immediately following every workplace injury.

Injuries not requiring immediate medical care:

The injured employee and supervisor must complete the company’s Accident Report regardless of whether medical care is needed at the time. The reasons for completing the required paperwork are:

- By reporting injuries (Company Name) can correct unsafe conditions or actions
- The injury may require medical care at a later date
- Should the injury require medical care at a later date (Company Name) will have the required information necessary for processing an L&I claim and completing our OSHA log.

Injuries requiring medical care:

- The Accident Report must be completed.
- If medical care is needed the employee must take the Injured Worker Packet to the doctor’s office and inform the doctor that (Company Name) has a return to work program and may provide temporary transitional work during recovery.
- The employee must return the Transitional Duty Form and the Activity Prescription Form the same or next day of their doctor’s visit to their supervisor.

If released to modified duty:

- The Claims Coordinator will provide you with a Job Offer Letter prior to starting the next shift.
- The supervisor must not assign work that exceeds restrictions, and you must work within your limitation as outlined by the attending physician.
- At each follow-up appointment you will provide the doctor or other medical practitioner with a new Transitional Duty Form and Activity Prescription Form for updating. The updated forms must be provided to your supervisor upon returning to work.
- All modified duty jobs are temporary in nature and (Company Name) anticipates you will be able to return to the job-of-injury.
Return-to-Work Authorization

(Required to be approved by Doctor)

Company name & address
Contact name & number

Employee:
Job Title:
Date of Injury:

Dear Attending Physician:

We are a proactive company and care about our workers. We recognize early Return-To-Work as being important to the workers’ psychological, financial, and physical wellbeing.

Your assistance is appreciated!

We have also included the job of injury, and a job description for a modified / light duty / transitional position we have available if our employee is not released to their job of injury. Further adjustment to these positions may be possible if needed.

Please complete the Activity Prescription Form and include any comments on our employee’s ability to work. Please give a copy of the completed form to our employee or fax to (Add Number).

Please call if you have any questions.

Sincerely,

__________________

Attending Physician

__________________

Date
**Employer's Job Description**

- **Workers**:  
- **Claim #**:  
- **Company**:  
- **Fax**:  
- **Phone**:  
- **Employer Name (Print/Put)**:  

**Hours per day**:  
**Days per week**:  
**Date**:  

**Essential Job Duties**

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**Machinery, tools, equipment and personal protective equipment**

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**Frequency Guidelines**

- **N**: Never (not at all)  
- **S**: Seldom (1-10% of the time)  
- **O**: Occasional (11-33% of the time)  
- **F**: Frequent (34%-66% of the time)  
- **C**: Constant (67%-100% of the time)  

**Physical Demands**

- **Sitting**:  
- **Standing**:  
- **Walking**:  
- **Climbing Ladders/Stairs**:  
- **Twisting at the waist**:  
- **Bending/ Stooping**:  
- **Squatting/Kneeling**:  
- **Crawling**:  
- **Reaching Out**:  
- **Working above shoulders**:  
- **Handling/ Grasping**:  
- **Fine Finger Manipulations**:  
- **Foot Controls/ Driving**:  
- **Repetitive Motions**:  
- **Talking/ Hearing/Seeing**:  
- **Vibratory Tasks**:  
- **Lifting**:  
- **Carrying**:  
- **Pushing/Pulling**:  

**Comments Other**:  

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**For Health Provider's Use Only**

- **Provider Approval**:  
- **Hours per day**:  
- **Days per week**:  
- **Effective Date**:  

If no, please provide objective medical documentation to support your decision.  

**Provider Signature**:  
**Provider Name (Print/Put)**:  
**Date**:  

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Physician’s Signature: ___________________________ Date: ___________________________
Sample Formal Job Offer to injured worker

Date:

Employee’s Name
Address
City, State, Zip Code

Re: Claim #__________

Dear _________:

Your doctor has released you for modified duty work, which he/she feels you are able to do until you can return to your regular job. Therefore, we would like to offer you the temporary, modified duty job of _________________. Attached is a copy of the job description approved by your attending doctor.

Please report to your immediate supervisor for your modified duty job on [insert date] at [insert time AM/PM]. Your pay will be $____ per ________(hour/month). Loss of Earning Power (LEP) benefits may apply if your restricted duty wage is less than your regular wage.

As you improve, the physical demands of the job may change, as approved by your doctor. Usually, a modified duty assignment lasts anywhere from a few days to several weeks, depending on your medical condition.

Your signature below indicates that you have reviewed this offer. Please return this signed job offer agreement to me by [insert date—10 to 14 days from date of letter]. A self-addressed, stamped envelope is enclosed for your convenience.

Should you have any questions about this job offer, please contact me at Your Phone#.

Sincerely,

CHECK ONE:

I accept this job offer: _________ I do not accept this job offer: _________

_________________________________ _____________________
Employee Signature Date

Enclosures: Approved Job Description Extra Copy of this letter for employee’s records

CC: Claims Manage