Note to Injured Worker: Provide this form to the attending Physician

******* REMINDER TO MEDICAL PROVIDER *******
EMPLOYEES ARE OUR MOST VALUABLE ASSET !

WE OFFER MODIFIED DUTY !!!

It is the policy of ______________________ *(company's name)* to aid an employee's rehabilitation by providing opportunities for returning to work at the earliest time possible. We will work to accommodate an employee's restrictions and provide them with work within those restrictions while they are in effect.

We will not ask an employee to do any work outside of their medically prescribed restrictions and expect them not to attempt any work that exceeds those restrictions.

If you have any questions regarding __________________ *(company's name)* modified duty program, please contact _____________________ *(contact person)* at ______________________ (phone number).

Thank you!

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(To be completed by Physician)

__________ Yes, employee may return to work on modified duty *(see restrictions).*

__________ No, employee may NOT return to work *(see restrictions).*

____
Physician's Signature

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Date
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