[Date]

[Employee Name]
[Employee ID]
[Department]

Subject: Approval of Medical Accommodation / Modified Duties

Dear [Employee Name],

This letter is to formally notify you that [Company Name] has approved your request for medical accommodation. Based on the medical documentation provided on [Date], we have identified modified duties that align with your current functional limitations.

Your modified work plan is scheduled to begin on [Start Date] and is currently set to expire or be reviewed on [Review/End Date].

Approved Accommodations and Restrictions:

- [Restriction/Limitation 1, e.g., No lifting over 10 lbs]
- [Restriction/Limitation 2, e.g., Must sit for 10 minutes every hour]
- [Modification 1, e.g., Reassignment of filing tasks]
- [Modification 2, e.g., Adjusted work schedule of 9:00 AM to 3:00 PM]

Expectations:

While on modified duties, you are expected to adhere to the restrictions outlined above. If you feel a task exceeds your medical restrictions, please notify your supervisor, [Supervisor Name], immediately. You are also required to provide updated medical documentation should your condition or restrictions change during this period.

We will meet on [Date/Frequency] to review the effectiveness of this accommodation and your progress. Please sign below to acknowledge your receipt and understanding of this modified duty plan.

Sincerely,

[Your Name]
[Your Title]
[Company Name]

Acknowledgment:

_____
[Employee Signature] / [Date]