

[Date]

[Employee Name]

[Employee ID]

[Department]

**Subject: Approval of Post-Surgery Workspace Modifications**

Dear [Employee Name],

Following your recent medical leave and the documentation provided by your healthcare provider dated [Date], we are pleased to inform you that your request for temporary workspace modifications has been approved.

To support your recovery and successful return to work, the following adjustments will be implemented effective [Start Date]:

- [Specific Modification 1, e.g., Ergonomic chair]
- [Specific Modification 2, e.g., Sit-stand desk converter]
- [Specific Modification 3, e.g., Footrest or modified lighting]
- [Other, e.g., Temporary relocation to a ground-floor desk]

These modifications are currently approved through [End Date/Review Date]. We will meet on [Date] to discuss your progress and determine if these accommodations need to be extended or adjusted based on further medical guidance.

Please coordinate with [Name/Department] regarding the delivery and installation of any equipment. If you experience any discomfort or find that further adjustments are needed, please notify [Contact Person] immediately.

We are committed to providing a safe environment for your recovery. Welcome back to the team.

Sincerely,

[Your Signature]

[Your Name]

[Your Title]

[Company Name]