Date: [Date]

To: [Employee Name]
Claim Number: [Claim Number]
Date of Injury: [Date of Injury]

Subject: Return to Work Evaluation Results

Dear [Employee Name],

Following your medical evaluation on [Date of Evaluation] with [Doctor's Name], we have received the updated report regarding your work status. Based on this evaluation, your current status is as follows:

[Select One Option Below]

- Full Duty: You are cleared to return to your regular position without restrictions effective [Date].
- Modified Duty: You are cleared to return to work with the following physical restrictions: [List Restrictions] effective [Date].
- Not Cleared: You are currently unable to return to work in any capacity. Your next evaluation is scheduled for [Date].

Work Offer:

[Employer Name] [has/has not] identified a position that meets the medical restrictions listed above. Your scheduled start date for this assignment is [Date] at [Time]. Your supervisor will be [Name].

Employee Requirements:

While working under these restrictions, you must not perform tasks that exceed the limitations set by your doctor. If you are asked to perform a task that violates these restrictions, you must notify [HR Contact/Manager Name] immediately.

Please sign below to acknowledge receipt of this evaluation and work offer.

Sincerely,

[Sender Name]
[Title]
[Company Name]

Acknowledgment:

Employee Signature

Date