

Date: [Date]

To: [Employee Name]

Employee ID: [ID Number]

Position: [Job Title]

Subject: Authorization for Modified Duty Medical Accommodation

Dear [Employee Name],

Based on the medical documentation provided by your healthcare provider, [Doctor's Name], dated [Date of Medical Note], [Company Name] has approved your request for a temporary modified duty accommodation.

This authorization is effective from [Start Date] and is currently scheduled to expire on [End Date or Review Date].

Prescribed Work Restrictions and Accommodations:

- [Restriction 1: e.g., No lifting over 10 lbs]
- [Restriction 2: e.g., Must be allowed to sit for 15 minutes every hour]
- [Restriction 3: e.g., Limited use of right hand/arm]
- [Other: e.g., Modified work schedule of 4 hours per day]

Modified Duty Assignment:

During this period, you are assigned to the following tasks: [Description of temporary tasks/duties]. You are strictly prohibited from performing tasks that exceed the medical restrictions listed above.

Reporting and Updates:

You are required to provide an updated medical evaluation from your physician no later than [Date]. If your medical status changes or if you find that you cannot perform the assigned modified duties, you must notify [Supervisor Name] or Human Resources immediately.

Please sign below to acknowledge that you understand these restrictions and the terms of this temporary accommodation.

Sincerely,

[Name of HR Representative/Manager]

[Title]

[Company Name]

Employee Acknowledgment:

I acknowledge receipt of this authorization and agree to adhere to the restrictions and duties outlined above.

Signature: _____ Date: _____