

[Date]

[Doctor's Name]

[Doctor's Facility Name]

[Address]

[City, State, Zip Code]

**RE: Job Duties Verification for [Employee Name]**

**Claim Number: [Claim Number]**

**Date of Injury: [Date of Injury]**

Dear [Doctor's Name],

In connection with the workers' compensation claim for the above-referenced employee, we are providing a formal description of the job duties for the position of [Job Title]. We request that you review these requirements to determine the employee's current ability to return to work.

**Physical Requirements and Essential Duties:**

- **Lifting/Carrying:** [e.g., Up to 50 lbs frequently]
- **Standing/Walking:** [e.g., 6 hours per 8-hour shift]
- **Sitting:** [e.g., 2 hours per 8-hour shift]
- **Reaching/Pushing/Pulling:** [e.g., Overhead reaching required occasionally]
- **Bending/Stooping/Kneeling:** [e.g., Frequent bending at the waist]
- **Environment:** [e.g., Warehouse setting, non-climate controlled]
- **Specific Tasks:** [List specific daily tasks here]

Please indicate below if the employee is cleared to perform these duties:

Full Duty: No restrictions.

Modified Duty: Cleared with the following restrictions: [\_\_\_\_\_]

Not Cleared: Unable to perform these duties at this time.

Please return this form or a signed medical report to our office via fax at [Fax Number] or email at [Email Address].

Sincerely,

[Your Name]

[Your Title]

[Company Name]

[Phone Number]

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**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_