

[Date]

[Employee Name]

[Employee ID]

[Current Department]

Subject: Approval of Temporary Medical Hardship Transfer

Dear [Employee Name],

We have reviewed your request for a temporary medical hardship transfer, along with the supporting documentation provided by your healthcare provider. We are pleased to inform you that your request has been approved.

The details of your temporary reassignment are as follows:

- **New Department/Location:** [Department Name/Branch]
- **Effective Date:** [Start Date]
- **End Date:** [End Date] (Subject to review)
- **Temporary Supervisor:** [Supervisor Name]
- **Work Schedule:** [Days and Hours]

This transfer is granted on a temporary basis to accommodate your current medical needs. Please note that your compensation and benefits will remain [unchanged / as follows: Detail any changes].

Prior to the end date mentioned above, we will meet to discuss your medical status and determine if you are able to return to your original position or if further accommodations are necessary. You are required to provide an updated medical release form from your physician before returning to your permanent role.

If you have any questions regarding this transfer, please contact the Human Resources Department.

Sincerely,

[Signature]

[Name of HR Representative/Manager]

[Title]

cc: [Department Manager Name]

Personnel File