LETTER FOR PROVIDER IDENTIFICATION OF TRANSITIONAL DUTY WORK AVAILABILITY

TO BE COMPLETED BY MEDICAL PROVIDER, GIVEN BY EMPLOYEE WHEN SEEKING INITIAL TREATMENT, AND MUST BE RETURNED BY THE EMPLOYEE TO MANAGEMENT

ATTENTION: Treating Healthcare Professional for _____ of _____.

This is to notify you that we have a temporary "Transitional Duty" return to work program for injuries resulting from job-related accidents.

Please complete the attached Authorization for Workers Compensation Medical Treatment Form and return to us with the employee after they have received treatment and you have had a chance to develop a recovery plan. This will help us in finding modified duty work within their limitations and capabilities you have outlined.

Please feel free to contact me at _____ if you have any questions about our return-to-work program.

We appreciate your cooperation and look forward to working with you as you help us promote a smooth recovery back to work.

Sincerely,

_____

WC Internal Claim Coordinator (Signature)

_____

(Date)