February 13, 2009

Mr. Sam Body
123 Main Street
Winnipeg, MB
X2X 2X2

Your Claim Number is 00006699

Dear Mr. Body:

This letter is to confirm the details of your return to work program with the ABC Company. Arrangements have been made for you to return to work on April 6, 2009.

At present, you are fit for modified duties with the following restrictions:

No lifting greater than 25 lbs.
No repetitive bending
Ability to sit and stand as required.

Your supervisor, John Smith is aware of your work restrictions and will provide you with modified duties. Please ensure you report any difficulties immediately to John and then contact myself to discuss as well.

These duties have been confirmed as:

Customer service at front desk
Light repairs at desk level
Answer incoming telephone calls
A sit/stand stool has been provided at the work site for your use

You will be working according to the following schedule:

April 6, 2009 – 2 hours per day
April 14, 2009 – 4 hours per day
April 20, 2009 – 6 hours per day
April 27, 2009 – full hours, regular duties

During this return to work program, your employer will pay for you hours worked and the WCB will issue partial wage loss benefits based on your gross earnings. I will be in contact with you and your employer on a regular basis to ensure your WCB benefits will be paid as per your due date.

I wish you all the best with your return to work. Congratulations on all the hard work you have put in towards your recovery to achieve this goal. As agreed, I will meet you at your work site on April 14, 2009 to monitor your progress further.

If you do not agree with the above decision, you have the right to appeal to the WCB's Review Office. Please see the enclosed information for appeal procedures.

If you have any questions, please call me at the number below.

Yours truly,

Ms. Case Manager
Rehabilitation and Compensation Services
(204) 954-4500
1-800-362-3340

cc: Dr. Smith
Supervisor
RTW Coordinator
Union Representative (if involved)

Employee: _____ Supervisor: _____

Objectives: Safe and timely return to pre-injury job
Avoidance of recurrence or new injury

Limitations: _____

Nature of the job:
Temporary assignment until complete recovery
Permanent job with modifications

Accommodations, if any: Hours of work
Reduced production
Alternate job

Length of assignments:
_____

What training is required?
_____

How long is the training?
_____

What are the safety precautions being taken during trainings?
_____
_____
_____

What is the job?
_____

What is the start date?
_____

What is the date by which the employee will be back to pre-injury job?
_____

Tasks:

_____
_____
_____
_____
_____

Safety Considerations:

_____
_____
_____

_____ _____

Employee's Signature Supervisor's Signature

_____ _____

Employee Representative Signature Manager's Signature

Company Name

Offer of Modified Work

Worker Name:

_____
(Print full name)

In an effort to assist you in an early and safe return to work, we would like to offer the following modified/alternate work placement.

The modified/alternate work position is: _____
(name or description of position and department or location)

The duties you will be required to perform are as follows:

_____

_____
(describe specific job duties and the physical requirements of the position)

The functional capabilities form indicates the following restrictions:

_____

The hours of work will be from: _____ (hrs) to _____ (hrs), _____ (days of week)

The duration of the modified work placement will be from: _____ (date) to _____ (date)

During the modified work placement your supervisor will be: _____
(name of supervisor)

Your rate of pay will be: __$_____
(pre-incident job rate recommended)

In keeping with the current functional capabilities provided by your healthcare provider, it is expected you will only perform the duties outlined above. Your supervisor will meet with you weekly to adjust your duties and/or length of placement as required based on your ability and progress in the return to work. If you have any difficulties performing the modified work please notify your supervisor immediately.

Worker signature: _____ Date: _____

Employer's signature: _____ Date: _____

IMPORTANT

For WCB cases provide: _____
Injured employee's WCB claim number

Fax directly to WCB Adjudicator/Case Manager _____ at 1-877-872-3804