

Date

FirstName LastName

Street Address, Suite/Apt.

City, WA Zip Code

RE: Claim Number Claim Number

Dear FirstName LastName,

According to the medical information received from your doctor, you are able to return to work in a transitional capacity effective (see attached medical information). We are offering you a **temporary transitional position** to help you return to your regular job; the position being offered is that of Job Title which requires the following:

The associated temporary transitional position will adhere to the work restrictions on the following page which also corresponds to the attached medical work release document from your Attending Provider.

1. You will report for duty on Report For Duty Date. Your shift will begin at Shift Start Time and will end at Shift End Time. You will be scheduled for 5 shifts per week.
2. You will report to Supervisor FirstName LastName, Supervisor Position Title, who will act as your direct supervisor.
3. Your wage will be $Hourly Wage Rate per hour and you will receive benefits in accordance with district policy.
4. If this position includes duties that you have not previously performed, training will be provided to help satisfactorily complete assigned duties.

Should you have any questions regarding this letter, please contact Adjuster FirstName LastName, your Workers’ Compensation Claims Adjuster, at (425) 917-Phone Number.

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| **Select one of the options below:** |
| [ ]  I accept this offer. | [ ]  I decline this offer and acknowledge that L&I time loss benefits may end. |  |
| Claimant FirstName LastName |  |  |
| Employee/Claimant Name | Employee/Claimant Signature | Date |