

OFFER OF MODIFIED WORK

COMPANY NAME: _____

EMPLOYEE NAME: _____
(Print full name)

In keeping with our policy to consider alternate suitable employment for any employee unable to perform their regular work due to injury, we are offering the following modified work placement.

The modified 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 hours of work will be from _____ to _____, _____
(Hrs) (Hrs) (Days of week)

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

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

Your rate of pay will be _____
(Pre-accident job rate recommended)

It is expected you will only perform the duties outlined above. _____ **Name of employer contact** will monitor your progress and meet with you weekly to adjust your duties and/or length of placement as required based on your ability and relevant fitness information. If you have any difficulties performing the modified work please notify your supervisor immediately.

Offer accepted

Offer rejected _____
(Reason)

Employee signature: _____ Date: _____

Employer signature: _____ Position: _____

IMPORTANT

For WCB cases provide: _____
(Injured employee's WCB claim number **OR** date of accident and SIN or birth date)

Fax directly to WCB adjudicator/case manager, if known, or to (780) 427-5863.