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. (*Insert name of supervisor*) 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 medical 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 & SIN or birth date)

Fax directly to WCB Adjudicator/Case Manager if known or to (780) 427-5863