acclaim
Ability Management Inc.

MODIFIED DUTIES OFFER

Employee Name _____ Employee ID#_____ Date _____

ABC COMPANY is committed to your rehabilitation through our early and safe return to work program. This letter will serve to confirm that effective immediately, the following safe and suitable modified duties are available:

STANDARD PRECAUTIONS

Back: Avoid repetitive trunk movement, Weight limitation for lifting, Avoid prolonged weight bearing, Avoid low level work, Avoid heavy pushing or pulling, No above shoulder level work.	**Neck:** Avoid repetitive neck movement, Avoid above shoulder level activity, Weight limitation for lifting.	**Shoulders:** Avoid repetitive shoulder activity, Weight limitation for lifting, Avoid above shoulder activity, No repetitive use of the upper extremity against resistance.	**Upper Extremity:** Avoid repetitive movement of the joint against resistance including bending, twisting, pulling and pushing, weight limitation for lifting.	**Lower Extremity:** Avoid repetitive movement of the join against resistance, No prolonged weight bearing, No rough ground walking, No low level activity or climbing of stairs and ladders.

Light Duties to be Preformed if the employee cannot return to full duties:

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Other

- Any other modified duties or special projects or assignments available within the facility that support your restrictions.
- Accommodations will be made for all restrictions up to the point of undue hardship for the company.

These modified duties are available:

- Effective immediately
- At no loss in wages
- At a self-paced tempo, with no productivity quota
- With the provision to rotate between these duties
- With the provision to sit/stand and take short breaks. A chair will be provided for all modified work.
- With transportation if medically supported and required

With your cooperation and participation in our program, ABC COMPANY is fully committed to ensuring your early and safe return to work. We hope that both you and your healthcare provider understand that if there is anything that we can do to help facilitate your early and safe return to work, such as providing transportation to and from your home, please do not hesitate to contact your manager or people leader.

You acknowledge that upon receipt of this letter you have been offered temporary modified work and have been informed of your responsibilities in the program.

The assigned modified duties may be adjusted based on the actual restrictions detailed on the Form 8 (in Ontario or Functional Abilities Form (FAF from your treating healthcare provider. Modified duties may vary based on business needs.

Please take the enclosed package to your physician. The package includes: letter to physician and FAF. Please have your physician complete the forms and send a copy to your manager and Acclaim immediately (as listed in the employee package. Your manager and Acclaim will work with you on your return-to-work plan.

Sincerely,

ABC COMPANY People Leader

I acknowledge that I have discussed modified duties with my Supervisor/Manager or Human Resources and understand my responsibilities during an early and safe return to work program.

In addition, by signing this document I understand that if I refuse suitable modified duties; it may change my entitlement to benefits through WCB. For more information on this please contact your provincial WCB.

_____	_____	_____
Employee Name	Employee Signature	Date
_____	_____	_____
Manager Name	Manager Signature	Date