

Modified Duty:

Employee Name:	Date of Birth:	Claim Number:
Employer: Check any/all "Available Tasks" boxes you can offe	r. Enter "Other" tasks you can	offer.
Physician: Please check "yes" or "no" to those tasks that the i	njured worker is capable of pe	rforming and sign below.

Employer Offer	Physician Response
Available Tasks	Release to Job Task?
	Yes No



Regular	_hrs./day or Reduced	hrs./day	
Employee Name	e:	Claim Number:	
Company Name	e:		
Employer Conta	act:		
Employer Phon	e:	Employer Fax:	
Employer Emai	l:		
•	nents on patient's ability to	perform Job Tasks:	
Physician Signa	ature:	Date:	