



R-8 Modified Duties Letter to Physician

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The Assurance Construction family of companies is committed to doing everything we can to achieve a successful recovery and return to work for our injured employees. Our Disability Management program is designed to help them return to work safely and at the earliest opportunity, using appropriate modified work alternatives when required.

We need your help! Please complete the fitness-for-work section at time of treatment and fax to the above number, or have our employee return it.

Authorization to Release Information (to be completed by injured employee)

Injury: _____ Injury date: _____

I hereby authorize my treating health care provider to release information related to my fitness for work.

Employee's name (Print): _____ Date: _____

Employee's signature: _____

Fitness for Work (to be completed by treating health care provider)

Examination date: _____ Injury: _____

This worker is:

- ☐ not capable of any work. How long? _____
- ☐ fit for regular work, no restrictions.
- ☐ fit for modified work with the following recommendations:

Specific fitness recommendations and physical restrictions:

☐ Sedentary ☐ Light ☐ Medium ☐ Heavy (see over for guidelines)

Estimated date fit for regular work: _____ Next appointment: _____

Health care provider's name: _____

Address: _____

Health care provider's signature: _____