

[Current Date]

[Injured Employee's Name]  
[Address]  
[Address]  
[City, State Zip]

**RE: Temporary Restricted or Light Duty Assignment**

Dear (Employee Name):

You are eligible for a Temporary Restricted or Light Duty Assignment as described in the enclosed *Return to Work Restricted or Light Duty Assignment* form. The tasks described are based on the Preferred Physician or Preferred Healthcare Professional's report. As you recover, your duty assignment will change based on the restrictions prescribed by your physician or other healthcare professional.

You will continue in your current job classification with ISU and there will be no change in your current salary or benefits. Similarly, your working hours will remain the same (however, your working hours may change) during this Temporary Restricted or Light Duty Assignment.

This Temporary Restricted or Light Duty Assignment is available immediately and will end when one of the following conditions are met:

- Your Preferred Physician or Preferred Healthcare Professional releases you for regular duty.
- Your Preferred Physician or Preferred Healthcare Professional indicates you have permanent restrictions or disability that will prevent you from returning to your regular job duties. In this case, contact the RTW Coordinator.
- Appropriate restricted or light duty assignments are not available or are no longer available.
- The term of your Temporary Restricted or Light Duty Assignment has ended.

If you have questions, contact me at [phone number] as soon as possible. We want you to feel secure in your return to work. Please come to my office on **(first day back upon arrival, e.g. Tuesday, 10/9/03 at 8:00 a.m.)** to discuss your temporary restricted or light duty assignment. After our meeting, you will proceed to your temporary duty assignment.

Your Temporary Restricted or Light Duty assignment:

Beginning Date: [report date]  
Place [department, location]  
Supervisor [name]  
Supervisor's Phone [number, ext]  
Work Shift: [start/stop time]  
Days Off: [days off]

If you are unable to report as assigned, please contact me as soon as possible before the

beginning date and start time above.

**NOTE: Your Workers Compensation benefits may be affected if you do not report as assigned or do not call as required, and you may be considered absent without approved leave. This may result in disciplinary action up to and including dismissal.**

We look forward to your rapid recovery and return to work. I will see you on your first day back.

Sincerely,

[Supervisor's Name]

c: RTW Coordinator  
Temporary Duty Supervisor  
State Insurance Fund