Modified Work Offer

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| Employer name |
| Employee last name | First name | Date (yyyy-mm-dd) |

We are committed to supporting your recovery and rehabilitation by providing a modified, flexible work environment to accommodate your needs.

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| Job position:      |
| Temporary Limitations/ Restriction:      |
| Specific duties:      |
| Hours of work per day      | Number of days per week      |
| Start date (yyyy-mm-dd)      | Review date (yyyy-mm-dd)      |
| Manager/ Supervisor’s name      |

**Please remember you are only to perform the duties allowed within your current limitations. If you have a change in your health condition and/or have any concerns with the modified/alternate work, please contact your Manager/ Supervisor immediately**

We will meet with you weekly to review your progress, starting on      (date yyyy-mm-dd).

|  |  |
| --- | --- |
| Employee’s signature | Date (yyyy-mm-dd)      |
| Manager/ Supervisor’s signature | Date (yyyy-mm-dd)      |

Please fax copy to WorkSafeBC at 1-888-922-8807 or 604-233-9777

**Include: Claim Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_