**{Date}**

**{Name}**

**{Title}**

**{Department}**

**{Address}**

RE: WCI – Return to work with Restrictions

**{Claim #}**

Dear **{Name}**,

The University of Texas at Austin has received a Texas Workers’ Compensation Work Status Report from your treating physician, {physician} name MD, dated {date}, relating to your current medical condition and your ability to work. A copy of that report is enclosed with this letter.

The University of Texas at Austin hereby extends to you a bona fide offer of employment pursuant to DWCC Rule 129.6, temporary alternate work assignment, not to exceed 90 calendar days from {date}.

If an employee is unable to return to work at full duty after 90 calendar days, he/she may request a continuation of Modified Duty not to exceed a total of 180 calendar days in a modified duty capacity. Approval beyond 90 calendar days will be based upon the assessment of the employee’s ability to return to full duty within the immediate future. An employee requesting an extension beyond the 90 calendar days must submit updated information from his/her treating physician.

An employee who is unable to return to his/her regularly assigned duties at the end of the Modified Duty agreement may request a leave of absence through his/her department or may elect to terminate his/her employment with the University.

You are allowed to return to work on **{date}** with the following restrictions as noted on the DWC-73 Texas Workers’ Compensation Work Status Report dated **{date}**:

* **{Maximum 4 hours kneeling/squatting per day}**
* **{No running}**
* **{Restrictions are specific to: left foot/ankle}**

You will report for work in **{name of dept / unit, location and room number}**. Your work schedule will be **{work schedule, time, number hours per day}** as specified by the standard operation procedures for your work shift.

Your temporary work assignment will consist of:

* **{Performing trouble calls for 4 hours per day}**
* **{Answering phones as needed}**
* **{Complete online Training}**

Your rate of pay will remain the same at **{$pay rate}** and you will continue working at your current title of **{title}**.

You are expected to bring updated medical documentation after your next doctor’s visit on {**date}**. At that time, we will review your work restrictions and work assignments.

Be assured that The University of Texas at Austin will only assign you tasks consistent with your physical abilities, knowledge, and skills, and will provide you training as necessary.

**{Department}** is aware of and will abide by any restrictions under which your treating physician has authorized your return to work. However, it is ultimately the employee’s responsibility to ensure he or she is staying within the confines of these restrictions. Your compliance with these restrictions is important to your prompt recovery and failure to comply with these restrictions may worsen your condition.

An employee may choose to accept or refuse the Return to Work (Modified Duty) job offer. An employee who refuses a Modified Duty job offer can be subject to termination and/or suspension of temporary income benefits.

Below is the website to the “Return to Work Program” policy for review:

<https://secure4.compliancebridge.com/utexas/public/getdoc.php?file=5-2240>

If your release includes work restrictions and are substantially limiting, or considered permanent, and you believe that you can perform the essential functions of your job duties with or without a reasonable accommodation, you will be required to provide information to the Office for Inclusion and Equity to initiate a request for ADA accommodation.

For information about ADA accommodation, please visit the following website:

<https://compliance.utexas.edu/programs/iaa/employee-ada-accommodations>

If you are experiencing stress or going thru a difficult emotional time regarding your work injury, counselors at the Employee Assistance Program (EAP) are available at no cost to you to discuss those concerns. You may schedule a confidential appointment by calling the EAP at (512) 471-3366.

If you have any other questions, you may contact me at {supervisor’s phone number}, or HRS - Strategic Work Force Solutions at (512) 475-7200.

Sincerely,

**{Name of Supervisor}**

**{Official Job Title}**

If you accept this offer, please indicate by signing your name and dating this form.

Acknowledged by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee’s Signature

Enclosure(s): DWC-73 – Texas Workers’ Compensation Work Status Report – **{Dr. physician}**, **{date}**

CC: **{Department contacts}**

Office for Inclusion and Equity

Employee File