Offers of Return to Work Modified Duty – Rule 6

When an employer can accommodate modified work restrictions, the employer can offer the employee an informal modified duty job offer.

If the employee refuses to cooperate with an informal modified duty job offer, then the employer should offer a formal return to work modified duty letter, known as a Rule 6 letter. This letter will provide the employee the structure for returning to modified duty. Your Sedgwick adjuster is available to answer any questions.

Step 1: Complete the Cover Letter to Authorized Treating Physician (see attached template).

Step 2: Complete the letter to Authorized Treating Physician with the proposed modified duties (see attached template). **Please note when sending the letter to the Authorized Treating Physician and it must also be sent to the employee (and claimant attorney if represented) at the same time and in the same manner.**

Step 3: Upon receipt of the approved/signed letter from the authorized treating physician, complete the letter to the employee regarding the modified duty job offer.

Step 4: Complete the modified duty packet for the employee. This should include the signed letter from the authorized treating physician, return to work status form and the modified duty letter to the employee.

Step 5: If hand delivering the modified duty letter to the employee, have the employee sign the certificate of receipt. If mailing, send the packet certified and regular mail with a certificate of service.

Step 6: Provide your adjuster a copy of the signed certificate of receipt.

_____

_____

_____

_____

Re: Employee Name: _____
Date of Injury: _____

Dear Dr. _____:

_____ is our employee, who sustained a work-related injury on _____. You are his authorized treating physician. We would like to return our employee to work in compliance with the restrictions that you have imposed, and wish to offer him modified duty approved by you. Please review the enclosure to this letter and sign it if you believe that the employment offered is within our employee's physical restrictions, and provide a statement on our employee's capacity to perform the offer of modified work. Please email me your signed statement at _____ or fax it to me at _____.

We appreciate your attention to this, so that _____ can return to work in the best capacity. If you require any additional information in order to complete this request, please contact me at _____.

Sincerely,

_____

_____

Enclosure

cc: Employee _____
Claimant Attorney (if represented) _____
Adjuster _____

DATE: _____

Offer of Modified Duty for _____

POSITION: _____

LOCATION: _____

REPORT TO: _____

WORK SCHEDULE: _____

WAGES: _____

Position Overview:

Mandatory Duties/Responsibilities: [Lifting Requirements, Duties, Specific Responsibilities]

Additional Details and Comments Regarding Job Duties: [Any other details for the ATP to know about]

I, _____, have reviewed the above job offer, and it is my opinion that the claimant, _____, has the physical capacity and ability to perform all of the job duties offered. I am approving this job offer by providing my signature below.

Physician Signature _____ Date: _____

[Please note that this form should be attached to the job offer subsequently provided to claimant]

_____

_____

_____

_____

Dear _____

This letter is to inform you that Dr. _____ has released you to return work with restrictions on the following date: _____. A copy of the doctor's report and/or work release is attached for your reference and records.

We are very pleased to inform you that we have modified work available within the doctor's release. We are offering you the following position:

Job Title:

Job Location:

Work Days:

Number of hours per Week:

Start Date:

Start Time:

Wage Rate:

Job Duties, Responsibilities, & Tasks: See attached duties outlined on the accompanying modified work duty description that Dr. _____ approved.

A copy of the job description is included for your review. This work is available as of _____.

Please report to _____ on _____ at _____ a.m.

Please also note, the refusal of this job offer will affect your workers' compensation benefits. If you have any questions about this letter or your claim, please contact me at _____.

Employer Name: _____

Title: _____

Enclosure

cc: Claimant Attorney (if represented): _____
Adjuster: _____

CERTIFICATE OF RECEIPT

I, _____, received the **Offer of Modified Duty Letter** by hand delivery on

_____.

Signed

_____ _____

Employee Name Date

CERTIFICATE OF SERVICE

I hereby certify that true and correct copies of the above and foregoing Offer of Modified Duty for _____ were served by placing the same in the United States mail, postage prepaid, or as otherwise indicated below, on the _____ day of _____, 2021, properly addressed to the following:

VIA CERTIFED and REGULAR Mail: ☐

Employee Name:

Address:

City, State and Zip:

VIA EMAIL: ☐

Adjuster Name:

Sedgwick

Claimant Attorney Email:

Claimant Attorney Name:

_____

Employer Representative