DALLAS COUNTY
HUMAN RESOURCES/CIVIL SERVICE

Department letter head

January 1, 2017

Date letter is being written

Jane Doe
1201 Elm Street
Dallas, Texas 75270

Employee Name & Address

RE: Bona Fide Job Offer - Workers' Compensation

45 day light duty expiration date, this date is 45 calendar days beginning on the date employee starts light duty.

Employee Name

Dear Ms. Doe,

Department Name

Data from report

Doctor name (Box 5)

Facility name (Box 6)

Dallas County is in receipt of a report dated January 1, 2017 from John Doe, Md. of Concentra relating to your current medical condition and your ability to work. A copy of that report is enclosed with this letter. Dallas County Sheriff's Department has used guidelines provided by the physician to identify an appropriate light duty position for you. This assignment may last up to a maximum of 45 days (or less, if you are released by your doctor) and will not be extended beyond **February 14, 2017**. If applicable, Family Medical Leave (FMLA) may be requested after this date. You were contacted on January 1, 2017 and verbally accepted our offer of light duty. Dallas County hereby extends to you a bona fide offer of employmen Rule 12

Supervisor name

Job assignment

Job duties

This assignment reports to Mr. Doe in Human Resources—Front Desk. Your task will include answering phones. You will be expected to return to work on January 1, 2017. Your work schedule will be as follows: Monday thru Friday, 8:00 a.m. to 4:30 p.m. Your wages will be the same as y

Date employee was notified of light duty assignment

Schedule

Date employee is notified to return to work.

Schedule

We acknowled ll be working under restrictions and want to emphasize the importance of working safety. Your restrictions are as followed: no climbing stairs or ladders. Therefore, it is important that you take responsibility for working within your restrictions.

Use boxes 14 thru 20 for restrictions.

This offer will be considered accepted by signing and dating your name below and returning this to the undersigned. If Dallas County does not receive this letter back from you within seven (7) days of the above date, Dallas County will assume you have rejected this offer.

Respectfully,

Supervisor name and signature

Workers' Compensation Specialist/Safety Officer

- ☐ I accept the light duty position offer to me and agree to fully comply with my doctor's restrictions.
- ☐ I refuse the light duty position offered to me

_____

Signature Date

Example

Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1-(800)-252-7031.

Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

5 Doctor's Name and Degree: John Doe, Md	(for transmission purposes only)	Date Being Sent: 1/1/2017	
1. Injured Employee's Name: Jane Doe	6 Clinic/Facility Name: Concentra	9 Employer's Name: Dallas County	
2. Date of Injury: 1/1/2017	3. Social Security Number (last 4): XXX-XX-	7 Clinic/Facility/Doctor Phone & Fax: 214-123-4567	10 Employer's Fax # or Email Address (if known): 214-123-4567
4. Employee's Description of Injury/Accident: Fell	8 Clinic/Facility/Doctor Address (street address): 123 Elm St	11 Insurance Carrier: York Risk Services	
	City: Dallas State: Tx Zip: 75270	12 Carrier's Fax # or Email Address (if known): 512-123-4567	

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

13. The injured employee's medical condition resulting from the workers' compensation injury

☐ (a) will allow the employee **to return to work** as of _____ (date) **without restrictions**

☑ (b) will allow the employee **to return to work** as of 1/1/2017 (date) **with the restrictions identified in PART III**, which are expected to last through 1/21/2017 (date).

☐ (c) has prevented and still prevents the employee **from returning to work** as of _____ (date) and is expected to continue through _____ (date)

The following describes how this injury **prevents the employee from returning to work:**

PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):	Max Hours per day: 0 2 4 6 8	Other	17. MOTION RESTRICTIONS (if any):	Max Hours per day: 0 2 4 6 8	Other
Standing	☐☐☐☐☐		Walking	☐☐☐☐☐	
Sitting	☐☐☐☐☐		Climbing stairs/ladders	☑☐☐☐☐	
Kneeling/Squatting	☐☐☐☐☐		Grasping/Squeezing	☐☐☐☐☐	
Bending/Stooping	☐☐☐☐☐		Wrist flexion/extension	☐☐☐☐☐	
Pushing/Pulling	☐☐☐☐☐		Reaching	☐☐☐☐☐	
Twisting	☐☐☐☐☐		Overhead Reaching	☐☐☐☐☐	
Other	☐☐☐☐☐		Keyboarding	☐☐☐☐☐	

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ Left Hand/Wrist ☐ Left Leg
☐ Right Hand/Wrist ☐ Right Leg
☐ Left Arm ☑ Back
☐ Right Arm ☐ Left Foot/Ankle
☐ Neck ☐ Right Foot/Ankle

Other:

16. OTHER RESTRICTIONS (if any):

Other

18. LIFT/CARRY RESTRICTIONS (if any):

☑ May not lift/carry objects more than 10 lbs for more than 0 hours per day

☐ May not perform any lifting/carrying

Other

19. MISC. RESTRICTIONS (if any):

☐ Max hours per day of work _____
☐ Sit/Stretch breaks of _____ per _____
☐ Must wear splint/cast at work
☐ Must use crutches at all times
☐ No driving/operating heavy equipment
☐ Can only drive automatic transmission
☐ No work / _____ hours/day work
☐ in extreme hot/cold environments
☐ at heights or on scaffolding
☐ Must keep _____ ☐ elevated ☐ clean & dry
☐ No skin contact with _____
☐ Dressing changes necessary at work
☐ No running

20. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)
☐ Advised to take over-the-counter meds
☐ Medication may make drowsy (possible safety/driving issues)

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work as well as at work.

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

22. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on _____ (date) at _____ : _____ am/pm
☐ Referral to/Consult with _____ on _____ (date) at _____ : _____ am/pm
☐ Physical medicine _____ X per week for _____ weeks starting on _____ (date) at _____ : _____ am/pm
☐ Special studies (list): _____ on _____ (date) at _____ : _____ am/pm
☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type	Role of Doctor	
1/1/2017			☐ Initial ☐ Follow-up	☐ Designated doctor ☐ Treating doctor ☐ Referral doctor ☐ Consulting doctor	☐ Carrier-selected RME ☐ DWC-selected RME ☐ Other doctor
Discharge Time: 11:00 am					