

INTERIM WORK RESTRICTION LETTER

Date

County of Los Angeles (Department Name)
Return to Work Coordinator
Address
City, State Zip

RE: Employee:
 Employee#:
 Dept#./Dept. Name:
 Claim #:
 DOI:

Dear Return to Work Coordinator:

Please be advised that the above mentioned employee was evaluated by their primary treating physician, _____ on _____ and has been provided with the following restrictions:

RESTRICTIONS

If you believe you can accommodate this employee, please engage in an interactive discussion with the employee to determine if they can return to a work hardening assignment or their usual and customary job.

The employee's status has not been determined to be permanent and stationary. A temporary work restriction letter will be sent following permanent and stationary status. If you have any questions, please call me at () -----.

Sincerely,
Intercare Insurance Services

Claims Examiner

c: EE
 Disability Unit
 Defense Counsel