



TEMPORARY WORK RESTRICTION

<<TODAY>>

County of Los Angeles/<<LOC_AND_NAME>>

Attn:

RE: Employee: <<FIRST_LAST_NAME>>
Employee No.: <<EMP_NO>>
Dept. No./Name: <<LOC_AND_NAME>>
Claim No: <<CLAIM_NO>>
DOI: <<DOI>>

Dear Return to Work Coordinator:

Please be advised that the above mentioned employee was evaluated by their primary treating physician, <<EE_PHYS_NAME>> (**Specialty**) on _____ and has been provided with the following work restrictions:

WORK RESTRICTIONS:

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. Please remember that you have 30 days from the last payment of Temporary Disability to offer the employee a job to minimize additional costs to the county.

If the employee can return to their usual and customary job, confirmation should be provided to the employee utilizing a DWC-AD 10118.

If the employee cannot return to their usual and customary position, a job offer should be made utilizing the RU-94 (for dates of injury before 1/1/04) or the DWC-AD 10133.53 (for injuries occurring on or after 1/1/04).

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

Sincerely,
Intercare Holdings Insurance Services

<<EX_NAME>>
Claims Adjuster

cc: CEO-Admin. Disability mailbox
<<DEF_ATTY_NAME>>