Date

Staff Name

Staff UCID

**Re: Offer of Modified Work**

Dear Staff Name:

In accordance with the *Workers Compensation Act* and the university’s commitment to providefaculty/staff members who are unable to perform their regular work due to a workplace injury or illness with suitable alternate employment, I am writing to offer you modified work.

I understand your limitations and restrictions are as follows:

List restrictions and limitations

**Modified Work**

Effective Start Date to End Date, the department will accommodate you in your Choose an item with the following modifications:

LIST ACCOMMODATION(S)

Please include the specific modifications to the regular job, i.e. “no lifting of garbage bags above 10 lbs”

Or

Specific responsibilities pertaining to the alternate position

**Responsibility**

The accommodation process is shared between you, (if applicable) Union/Association, and the University. As such, you are responsible for advising management if your situation changes, or if the agreed-upon solution is not working as it was intended.

You are responsible to continue to work with management and actively participate in the modified work, including being open to trying all reasonable offers of accommodation despite that it may not be your preferred accommodation.

It is expected you will only perform the duties outlined above. If you have any difficulties performing the modified work please notify me immediately.

**Review Period**

On or around, Review Date, we will reconvene to review and discuss your accommodation. (if applicable) Your union/association representative is welcome to accompany you at this meeting.

Sincerely,

Manager Name

Manager Title

**Signatures**

|  |
| --- |
| Offer Accepted |
| Staff Name (Print) | **Staff Signature** | **Date** |
| Print Staff Name |  | Date |
| Union/Association Rep (Print)*(if applicable)* | **Union/Association Rep Signature** | **Date** |
| Print Union/Association Rep Name |  | Date |

|  |
| --- |
| Offer Refused |
| I have chosen to refuse the above offer of modified work for the following reason(s): |
| Enter Rationale |
| Staff Name (Print) | **Staff Signature** | **Date** |
| Print Staff Name |  | Date |
| Union/Association Rep (Print)*(if applicable)* | **Union/Association Rep Signature** | **Date** |
| Print Union/Association Rep Name |  | Date |

Cc: HR Partner/Advisor, Staff Wellness