Date

Employee Name

Address

City, State, Zip

Dear Employee,

Employer Name is dedicated to creating a safe workplace for employees. When a workplace injury does occur, we are also committed to supporting our employee's continued engagement in the workplace and return to regular work activities through Temporary Transitional Work Assignments (TTWA). You are receiving this letter due to your recent workplace injury. It includes your TTWA ***offer***. Please review this information fully.

**Key components of temporary transitional work assignments:**

* Employer Name firmly believes TTWAs assist our employees in returning to regular work activities in the most appropriate and timely manner.
* TTWA assignments are required to be within the scope of activities determined by your medical provider. This scope is communicated in the medical status form completed by your medical provider. Please find a copy of this medical status form attached.
* The scope of your approved activities has been reviewed with your supervisor. Any tasks assigned to you must be within the scope determined by your medical provider.
* Working outside the scope determined by your medical provider puts you at risk of further injury and is ***not acceptable***. If at any time you are concerned or having difficulty with your assigned activities, you must notify your supervisor immediately.
* Declining a TTWA offer may make additional lost time benefits unavailable to you. It is your responsibility to make sure you fully understand both the TTWA offer and the implications of declining this offer.

**Key components of your TTWA offer:**

* Your wage for this temporary transitional assignment will be \_\_\_\_ with \_\_\_\_ hours of work available per week.
* Your supervisor will meet with you each week and after each appointment with your medical provider to review the appropriateness and continued availability of your TTWA.
* You must respond to this TTWA offer by the end of business day on Date by indicating your acceptance or declination below and providing the signed letter to your name of Employer representative to receive offer letter response.

If you have any questions or would like to discuss this TTWA offer further, please contact me.

Sincerely,

Employer Contact Person

Organizational Name

Contact Information

**To be completed by name of injured Employee:**

[ ]  Yes, I accept this temporary transitional work assignment offer.

[ ]  No, I do not accept this temporary transitional work assignment offer.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

CC: Claims Examiner – Montana State Fund

Enc: Copy of Medical Status Form