**THIS IS A SAMPLE ONLY AND IS NOT INTENDED TO SERVE AS LEGAL ADVICE, NOR IS THIS LETTER APPROPRIATE IN EVERY CIRCUMSTANCE. THE REQUIRED LANGUAGE BELOW WAS ACCURATE AS OF 12/11/24 BUT SHOULD BE VERIFIED BEFORE EACH LIGHT DUTY JOB OFFER.

Date

Address

Dear _____,

We understand that you are currently unable to return to work in your typical position with _____. At this time, the employer is pleased to offer a temporary modified/light duty job.

Attached is a brief job description setting forth the physical requirements of your temporary modified/light duty job. Your attending physician has found the job to be within your capabilities and the commute to be within your physical capacity, per the attached.

Your modified duty job begins on _____ at ____ a.m. The job is located at:_____. You will be paid at a rate of $_____per hour. There will be a total of 40 hours of work per week available for you Monday through Friday. Your hours are 8:00 a.m. to 5:00 p.m. The duration of this position is _____.

You have the right to refuse this offer of employment without termination of temporary total disability if any of the following conditions apply:

(i) The offer is at a site more than 50 miles from the location where the worker was injured or where the worker customarily reported for work, unless the work site is less than 50 miles from the worker's residence, or the job at the time of injury involved multiple or mobile work sites as established by the intent of the employer and worker at the time of hire or the employment pattern before the injury;
(ii) The offer is not with the employer at injury;
(iii) The offer is not at a work site of the employer at injury;
(iv) The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or
(v) The offer is not consistent with an existing shift change provision of an applicable union contract.

If you refuse this offer of work for any of the reasons listed in this notice, you should:
- Write to the insurer or employer, and
- Tell them your reasons for refusing the job.
If the insurer reduces or stops your temporary total disability, you may appeal by requesting a hearing. To request a hearing, send a letter objecting to the insurer's actions to:
Worker's Compensation Board
2601 25th Street SE, Suite 150
Salem OR 97302-1280

Please review the above carefully and indicate below:

_____ I accept this position _____ I decline this position

_____ _____/_____/_____
[CLAIMANT NAME]