UNITED STATES POSTAL SERVICE

Date: _____

# OFFER OF MODIFIED ASSIGNMENT (LIMITED DUTY)

| Employee Name | DOI | Employee ID | OWCP Claim # |
|---|---|---|---|
| | | | |

| Office/Work Location (Name) | Pay Loc | Date of Injury Employee Position Title |
|---|---|---|
| | | |

This letter is written confirmation of a modified assignment offer related to the above referenced on-the-job injury.

WORKHOURS: _____ OFFDAYS: _____

LOCATION: _____ LEVEL/STEP: _____

EFFECTIVE DATE: _____ SALARY: _____

POSITION TITLE: (MODIFIED) _____ OCC CODE: _____

| The duties of this modified assignment will consist of: | Avg Time Spent | LDC/OPN |
|---|---|---|
| ❑ | | |
| ❑ | | |
| ❑ | | |
| ❑ | | |

*(Provide attachment if additional space is necessary/Other Duties As Assigned Is Not Acceptable)*

| The physical requirements of this modified assignment are: | Avg Time Spent |
|---|---|
| ❑ | |
| ❑ | |
| ❑ | |
| ❑ | |

*(Provide attachment if additional space is necessary)*

Name of Supervisor/Manager Completing Worksheet (Please Print) Office

Supervisor/Manager Signature Phone #

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___I accept/___I reject the modified assignment offer: (EXPLAIN) _____

_____

Employee's Signature Date

*(See reverse side for additional information relating to this modified assignment)*

Original (Top Copy) - Employee Middle Copy – Injury Compensation Control Office Bottom Copy - Supervisor/Work Area

**PS Form 2499X, August 2003**