Dear Treating Health Care Provider of our valued employee:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Employer) values our employees and is concerned for the individual welfare of all employees. In the event of a workplace injury, we want to put injured workers back to work in a safe, productive capacity as soon as possible while they are recovering. By doing so, we seek to contribute to the medical recovery of injured workers by providing meaningful work activities as approved by you, their treating health care provider.

We have a return-to-work program and if one of our employees is unable to return to his/her original job, we will make every attempt to return this employee to modified or light duties. We will also ensure that these duties meet with ALL medical restrictions that you prescribe and will monitor/support our worker during this process. If necessary, we are willing to rearrange work schedules around diagnostic or treatment appointments.

To assist in this process, we have enclosed for your review:

* The Notice of Accident form describing the incident
* Provider’s Report of Physical Ability

We ask that you fill out the “Provider’s Report of Physical Ability” form after each appointment. **Please give the completed “Provider’s Report of Physical Ability” back to our worker so they may inform us of any work restrictions that we can accommodate**.

Thank you in advance for your assistance in our early return-to-work efforts.

If you have any questions, please contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_(company workers’ comp contact) at phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_ or by email at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Please route bills to our workers’ compensation TPA:**

CCMSI

PO Box 30870

Albuquerque NM, 87190-0870

Phone: (505) 837-8700

Sincerely,

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Company workers’ comp contact