U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT XX
LONDON, KY 40742-8300
Phone: (xxx) xxx-xxxx

Date of Injury:
Employee:

Dear XX XXXXXX:

I am writing in reference to the above patient, whose workers' compensation case with this office has been accepted for . Your patient is expected to return to work when no longer totally disabled because of the accepted condition. We do not presently have your estimate of the date by which you expect your patient to be able to return to full or restricted duty.

If your patient is now able to work with certain restrictions, please complete and return the enclosed work restriction form OWCP-5a, OWCP-5b, OWCP-5c. If not, please keep this questionnaire and send it to us as soon as your patient reaches that status.

You may bill us your usual fee for your response using form HCFA-1500. Thank you for your assistance.

Sincerely,

Enclosure(s):

OMB Clearance #1215-0103 Exp. Date 10/31/2008

NOTICE TO RECIPIENT

The information requested is required for the claimant to obtain or retain a benefit under 5 U.S.C. 8101 et seq. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

We estimate that it takes an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S-3229, 200 Constitution Avenue, NW, Washington, DC 20210.

DO NOT SEND THE INFORMATION REQUESTED TO THE ADDRESS SHOWN JUST ABOVE. RATHER, SEND IT TO THE ADDRESS SHOWN ON THE LETTERHEAD.