



Mark Gordon  
Governor

State of Wyoming  
Department of Workforce Services  
DIVISION OF WORKERS' COMPENSATION  
5221 Yellowstone Road  
Cheyenne, Wyoming 82009  
<http://www.wyomingworkforce.org>



Robin Sessions Cooley  
Director  
Elizabeth Gagen, J.D.  
Deputy Director

RE: Claim Name:  
Claim Number:

Light Duty

The Division has received medical documentation indicating the above referenced injured worker was released to return to work in a light duty or part time capacity. An employer is not required to make an offer of light duty work to an injured employee. However, the Division would like you to consider giving your employee an opportunity to rejoin the work force at this point in his/her recovery.

According to W.S. § 27-14-404(j), both an employer and an employee can benefit when light duty work is offered and accepted. In order for an employer to qualify for the benefit, an offer of light duty must be in writing, on a form supplied by the Division. The terms of the offer must be complied with as stated on the agreement form. The injured employee's treating physician, or other licensed health care provider, must certify the work offered is suitable for your employee and accommodates the employee's physical restrictions.

When an employer makes a written offer of light duty or part time work, and the employee accepts the offer, the employer's workers' compensation account will **not** be charged for the compensation benefits paid to the employee as long as all terms of the agreement are met. The employee's income should increase due to the fact he/she would earn reduced wages in addition to receiving temporary light duty benefits from the Division. The temporary light duty benefits are paid at 80% of the difference between the employee's light duty wage and the employee's actual monthly earnings at the time of injury not to exceed the statewide average wage for the period in which injury occurred.

Pursuant to W.S § 27-14-404(j), it is the responsibility of the employer to supply the Division with a copy of the payroll information and/or pay stubs for their employee no later than the 15th of the month following the payment of light duty wages. Temporary light duty benefits cannot be paid until this information is received. Payroll information and/or pay stubs may be faxed to the Division at 307-777-6552.

TTD benefits will be reduced to 1/3 if an employee refuses a bona fide written offer of light duty. When an employer makes a written offer of light duty work, and the employee refuses the offer, the employer's account will **not** be charged if all of the following conditions are met.

CONDITIONS:

1. The Division's Agreement For Light Duty/Restricted Work form was used;
2. The light duty work was approved by a licensed health care provider;
3. The Light Duty Agreement must specify the number of days per week, the number of hours per day, the rate of pay per hour and the employee must work the specified days and hours;
4. The light duty work assignment does not exceed 12 months.

When an employee returns to work, in any capacity, for wages that "substantially restore" his or her earning power, the employee's TTD benefits will terminate. Earning power is "substantially restored" when the wages earned are the equivalent of 95% of the employee's pre-injury wage.

A verbal agreement, or a written agreement on anything other than the Division's form, will not be accepted or honored by the Division. If the agreement is verbal, or any other form is used, the injured employee's TTD benefits will not be reduced, and compensation payments will continue, in full, until the employee returns to gainful employment or qualifies for permanent partial impairment or permanent total disability benefits. The TTD payments will be charged to the employer's account.

A copy of the Agreement For Temporary Light Duty/Restricted Work form is attached to this letter for your convenience, to use when offering light duty work to your employee. Please provide all information requested on the form. When signed by all parties, please provide a copy to each party, returning one copy to the Division. The Division cannot take any action until it receives a copy of the signed agreement form. If you need more information regarding light duty agreements and benefits, please call me at your earliest convenience. If you have any questions, please contact me directly at (307).

Sincerely,

cc: Injured Worker  
WCD File



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**Agreement for Temporary Light Duty / Restricted Work**

Employer Name:  
Address:  
City, State:  
Zip:

Employee Name: Claim Name  
Claim Number:  
Address:  
City, State:  
Zip:

**Terms of Light Duty / Restricted Work**

On this date, \_\_\_\_\_, the employer named above, makes the following offer of light duty work to the employee named above. The number of days per week will be \_\_\_\_\_, and the number of hours per day will be \_\_\_\_\_. The wage for this position will be \$\_\_\_\_\_ per \_\_\_\_\_. This position begins \_\_\_\_/\_\_\_\_/\_\_\_\_. Expected duration of this position is \_\_\_\_\_ days.

The duties of this position are: \_\_\_\_\_

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

The maximum physical requirements of this position are listed below:

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

**EMPLOYER CERTIFICATION**

I certify I am the employer or authorized to represent the employer offering light / restricted duty to employee in good faith and in accordance with Wyoming Statute [The Act] § 27-14-404(j).

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

Claim Name:  
Claim Number:  
Date of Injury:  
Page 2

Physical limitations provided by the employee's doctor are listed below:

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The anticipated date of return to unrestricted work for this employee is \_\_\_\_/\_\_\_\_/\_\_\_\_.  
This is subject to change with proper medical documentation and justification. The offer will not extend beyond the requirements of Wyoming Statute § 27-14-404 (b).

### HEALTH CARE PROVIDER CERTIFICATION

I certify I have examined this employee and agree the physical and mental requirements and restrictions of this light duty position are within the employee's limitations. I hereby authorize employee to return to work subject to the light duty restrictions stated in this agreement.

\_\_\_\_\_  
Printed Health Care Provider Name

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Date

### EMPLOYEE CERTIFICATION

I certify I will follow the doctor's medical restrictions. I agree to immediately notify the Division of Worker's Compensation and my employer of any change in my restrictions with a written note from my health care provider. I agree to notify the Division and my health care provider(s) immediately if I return to full time employment. I also agree to contact my claims analyst if any problems arise regarding the temporary light duty assignment. I understand Temporary Partial Disability benefits will be paid monthly.

I accept employer's offer for light duty work.

I refuse employer's offer for light duty work.

\_\_\_\_\_  
Print Employee Name

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Reason for refusal (optional): \_\_\_\_\_

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