DWC-AD 10003 NOTICE OF OFFER OF REGULAR WORK
For injuries occurring on or after 1/1/05

THIS SECTION TO BE COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR:

Claims Administrator:____Claim Number:____________________
(Name of Claims Administrator)

Based on the opinion of__treating physician__QME__AME__________________________, you are able to return to
(Name of Physician)

your usual occupation or the position you held at the time of your injury on____________________________.
(Date)

Date you are eligible to return to job:__________________________(as stated in the above physician's report)

Employer:____
(Name of Firm)

Job Title:____

Starting Date:_______________________________________

__ This position is at the same location and shift as your pre-injury position.

__ This position is at a different location than your pre-injury position, as follows:________________________

____

__ This position is for a different shift than your pre-injury position, as follows:__________________________
(start time) (end time)

You may contact ______________________________concerning this position. Phone No.:________________
(Name of Contact Person)

You must return the completed form to the employer or claims administrator listed here:

____
(Name of Employer or Claims Administrator) (Mailing address)

This position is expected to last for a total of at least 12 months of work. If this position does not last for a total of at least 12 months of work, you may be entitled to an increase in your permanent disability benefit payments.
This position provides wages and compensation of $______________________, that are equivalent to or more than the wages and compensation paid to you at the time of your injury.
I,_______________________________________, have obtained the above job offer information from your employer.
(Name of Claims Administrator)

If the job offered is at a different location than the job you held at the time of your injury, and you believe the commuting distance to this job from the residence where you lived at the time of your injury is not reasonable, you may object to the job offer as not being within a reasonable commuting distance. You may also waive this commuting distance requirement. You will be considered to have waived this requirement if you accept the above offer of work or do not reject the offer within twenty calendar days of receipt of this notice.

THIS SECTION TO BE COMPLETED BY EMPLOYEE: **Claim Number____________________**

The employee must accept, reject, or object to this offer for regular work and return this form to the employer or claims administrator listed on page one within 20 calendar days of receipt of the offer or it will be deemed that the employee has waived the right to object to the location or shift. The employee should keep a copy of this form for his or her records.

Name of employee:__________________________________ Date offer received:_________________________

I understand that if my disability is permanent and stationary and the employer has fulfilled its legal obligations related to this offer, my remaining permanent disability payments will be decreased by 15% whether I accept or reject this offer.

Offer of Regular Work at Same Location and/or Shift

__ I accept this offer of regular work.

__ I reject this offer of work. Reason:____

Note: If either party has a dispute or objection regarding the offer of regular work, or if the employee rejects the offer of regular work, that party may file a Declaration of Readiness with the local district office of the Workers' Compensation Appeals Board (WCAB).

Offer of Regular Work at a Different Location and/or Shift

I understand that I have the right to object to a work offer when the location or shift is different than what I had at the time of my injury.

__ I accept the offer and waive my right to object to the job location or shift as not being within a reasonable commuting distance from the residence where I lived at the time of my injury.

__ I reject this offer of work. Reason: ____

__ I object to this offer because the job location that has been offered is different than the job location I held at the time of my injury, and I do not believe this job allows a reasonable commute from my residence. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

__ I object to this offer because the job shift that has been offered is different than the job shift I held at the time of my injury. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

Note: If either party has a dispute or objection regarding the offer of regular work, or if the employee rejects the offer of regular work, that party may file a Declaration of Readiness with the local district office of the Workers' Compensation Appeals Board (WCAB).

____ Date: ____________________________

Signature

Proof of Service By Mail or Hand Delivery

I am a resident of the County of ________________________________. I am over the age of eighteen years and not a party to the within matter. My business address is:

____.

On ________________________________, I served the **Notice of Offer of Regular Work** on the party/parties listed below by either method of service described below:

A. Placing a true copy of the **Notice of Offer of Regular Work** in a sealed envelope with postage fully prepaid addressed to each person whose name and address is given below by depositing the envelope in the United States mail.

Or

B. Personally serving a true copy of the **Notice of Offer of Regular Work** on each person whose name and address is given below.

Enter the name of the party and indicate the type of service in the box (either A or B as described above.)

Name of Party:	Type of Service
____	☐
____	☐
____	☐
____	☐

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at

____on ________________________________.

Signature:____

MANDATORY FORMAT
STATE OF CALIFORNIA
September 2006
8 CCR 10003