NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

THIS SECTION COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR:

Employer (name of firm)_____ is offering you the position of a

(name of job) _____.

Attach a list of the duties required of the position.

You may contact _____ concerning this offer. Phone No.: _____

Date of offer: _____. Date job starts: _____.

Claims Administrator:_____Claim Number:_____

NOTICE TO EMPLOYEE Name of employee: _____

Date offer received: _____

You have 30 calendar days from receipt to accept or reject this offer of modified or alternative work. If you reject this job offer, you will not be entitled to rehabilitation services unless:

Modified Work

A. The proposed modification(s) to accommodate required work restrictions are inadequate.
B. The modified job will not last 12 months.

Alternative Work

A. You cannot perform the essential functions of the job; or
B. The job is not a regular position lasting at least 12 months; or
C. Wages and compensation offered were less than 85% ~~of the wages~~ paid at the time of injury; or
D. The job is beyond a reasonable commuting distance from residence at time of injury.

THIS SECTION TO BE COMPLETED BY EMPLOYEE

__ I accept this offer of Modified or Alternative work.

__ I reject this offer of Modified or Alternative work and understand that I am not entitled to vocational rehabilitation services.

_____ Date _____

Signature

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

If the offer is not accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the employee.

All employees must present documents required for completion of *INS Form I-9* prior to starting modified or alternative work.

The employer or claims administrator must forward a completed copy of this agreement to the Rehabilitation Unit with a Notice of Termination (DWC Form RU-105) within 30 days of acceptance or rejection.

If a dispute occurs regarding the above offer or agreement, either party may request the Rehabilitation Unit to resolve the dispute by filing a Request for Dispute Resolution (DWC Form RU-103) at the applicable Rehabilitation Unit. The Rehabilitation Unit venue is the same as the Workers' Compensation Appeals Board. If no WCAB case exists, file with a Rehabilitation Unit at ~~within~~ the appropriate district office. ~~county where the injured employee resides.~~

MANDATORY FORMAT
STATE OF CALIFORNIA
DWC-RU-94 (10/02/02)