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State of California
Division of Workers' Compensation

NOTICE OF OFFER OF REGULAR, MODIFIED, OR ALTERNATIVE WORK FOR INJURIES OCCURRING ON OR AFTER 1/1/13
DWC - AD 10133.35

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR (All information in this section must be completed):

Claims Administrator Type: (Please Choose One)

☐ Insurance Company ☐ Third Party Administrator ☐ Employer

_____ is offering you _____
Employer Name (Employee Name)

the position of a _____
Name of Job

This offer is for: ☐ Regular Work ☐ Modified Work ☐ Alternative Work

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

Date of offer: _____ Date job starts: _____
MM/DD/YYYY MM/DD/YYYY

_____
Claims Administrator

_____
Claims Representative Claim Phone Number

_____
Claims Address Claim Number:

(Choose only one)

☐ a specific injury on _____
MM/DD/YYYY

☐ a cumulative trauma injury which began on _____ and ended of _____
(START DATE: MM/DD/YYYY) (END DATE: MM/DD/YYYY)

Date of Birth: _____
MM/DD/YYYY

You have 30 calendar days from receipt to accept or reject the attached offer of work. However, if you fail to respond in 30 days or reject this job offer, you will not be entitled to the supplemental job displacement benefit unless the offer is for modified work or alternative work and:

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 are less than 85% paid at the time of injury; or
D. The job is beyond a reasonable commuting distance from residence at time of injury.

POSITION REQUIREMENTS

Actual job title: _____

Wages: $ _____ Per hour ☐ Week ☐ Month ☐ Year ☐

Is salary of regular/modified/alternative work the same as pre-injury job? Yes ☐ No ☐

Is salary of regular/modified/alternative work at least 85% of pre-injury job? Yes ☐ No ☐

Is job expected to last at least 12 months? Yes ☐ No ☐

Is the job a regular position required by the employer's business? Yes ☐ No ☐

Work location: _____ ☐ Same as Pre-Injury Position

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. The employee should keep a copy of this form for his or her records.

☐ I accept the offer and waive any 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.

☐ Position is for a different shift. The shift time is _____ (Start Time) - _____ (End Time)

Duties required of the position:

Description of activities to be performed (if not stated in job description):

Physical requirements for performing work activities (include modifications to usual and customary job):

Name of doctor who approved job restrictions (optional): ☐ PTP ☐ QME ☐ AME

Date of report: _____
MM/DD/YYYY

Proof of Service by Mail
(To Be Completed By the Employer or Claims Administrator)

I declare that: On _____ ,

I served the attached on:

☐ by placing a true copy thereof enclosed in a sealed envelope with postage thereon fully paid, in the United States mail.

☐ by personal service.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that this declaration was exectuted on: _____ at _____ , CA.

Signature: _____

Print Name: _____

THIS SECTION TO BE COMPLETED BY EMPLOYEE (All information in this section must be completed)

☐ I accept this offer of Regular, Modified, or Alternative work.

☐ I reject this offer of Regular, Modified, or Alternative work and understand that I may not be entitled to the Supplemental Job Displacement Benefit.

☐ 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 that this offer is expected to last at least 12 months. If seasonal work is being offered, I understand that the 12 months may be satisfied by cumulative periods of seasonal work. In the event this position ends or I am laid off prior to working 12 months, I understand that I may be entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I may not be entitled to the Supplemental Job Displacement Benefit.

I feel I cannot accept this offer because:

Signature: _____ Date: _____
MM/DD/YYYY

NOTICE TO THE PARTIES

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

If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director, Division of Workers' Compensation, P.O. Box 420603, San Francisco, CA 94142-0603.