

DWC-AD 10133.53 NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK
For injuries occurring on or after 1/1/04

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR:

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

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 of Injury: _____ Date offer received: _____

You have 30 calendar days from receipt to accept or reject the attached offer of modified or alternative work. Regardless of whether you accept or reject this offer, the remainder of your permanent disability payments may be decreased by 15%. 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:

Modified Work ☐ **or 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 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.

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 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.

Signature Date _____

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.

The employer or claims administrator must forward a completed copy of this agreement to the Administrative Director within 30 days of acceptance or rejection. (A.D., "SJDB," Division of Workers' Compensation, P.O. Box 420603, S.F., CA 94142-0603)

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.

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POSITION REQUIREMENTS

Actual job title:	
Wages: \$	per Hour Week Month
Is salary of modified/alternative work the same as pre-injury job?	Yes ___ No ___
Is salary of modified/alternative work at least 85% of pre-injury job?	Yes ___ No ___
Will job last at least 12 months?	Yes ___ No ___
Is the job a regular position required by the employer's business?	Yes ___ No ___
Work location: _____	

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): _____ Date of report: _____
Date of last payment of Temporary Total Disability:
Preparer's Name:
Preparer's Signature: _____ Date _____

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Proof of Service By Mail

I am a citizen of the United States and 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 Modified or
Alternative Work** on the parties listed below by placing a true copy thereof enclosed in a sealed
envelope with postage fully prepaid, and thereafter deposited in the U. S. Mail at the place so
addressed.

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: _____

Copies Served On: _____