State of California
Division of Workers' Compensation
Retraining and Return to Work Unit

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

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 of firm)

the position of a _____.
Name of Job

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

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

_____
Claims Administrator:

_____
Claim Number:

NOTICE TO EMPLOYEE (All information in this section must be completed)

Name of employee: _____ _____
First Name Last Name

(Choose only one)

☐ a specific injury on _____
MM/DD/YYYY

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

Date offer received: _____ Date of Birth: _____
MM/DD/YYYY MM/DD/YYYY

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.

POSITION REQUIREMENTS (All information in this section must be completed)

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: _____
MM/DD/YYYY

Date of last payment of Temporary Total Disability: _____
MM/DD/YYYY

Preparer's Name: _____

Preparer's Signature: _____

Date: _____
MM/DD/YYYY

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

☐ 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: _____
MM/DD/YYYY

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.