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

NOTICE OF OFFER OF REGULAR WORK
For injuries occurring on or after 1/1/05

DWC - AD 10118

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

Claims Administrator Type

☐ Insurance Company ☐ Third Party Administrator ☐ Employer _____ Case Number

Claim Number _____

Claims Administrator _____
(Name of Claims Administrator)

_____ _____
Injured Employee First Name MI

_____ _____
Injured Employee Last Name Date of Birth: MM/DD/YYYY

Based on the opinion of: ☐ Treating Physician ☐ QME ☐ AME

_____
(Name of Physician)

you are able to return to your usual occupation or the position you held at the time of your injury on

(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 you are eligible to return to your job _____ (as stated in the above physician's report) ,
MM/DD/YYYY

Employer _____
(Name of Firm)

Job Title _____ Starting Date _____ .
MM/DD/YYYY

☐ 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. The location is:

_____

☐ This position is for a different shift than your pre-injury position. The shift time is _____ — _____
(Start Time) (End Time)

You may contact _____ at _____ concerning this position.
(Name of contact person) Phone Number

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

Claims Administrator (To Be Completed By The Employer or Claims Administrator) (All information in this section must be completed)

_____
Name

_____
Claims Mailing Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

_____ _____
Claims Representative Phone

This position provides wages and compensation of $ _____ , that are equivalent to or more than
Weekly Wages

the wages and compensation paid to you at the time of your injury.

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.

I , _____ have obtained the above job offer information from your employer.
(Name of Claims Administrator)

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

Case 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 the form within 20 calendar days of receipt of the offer or it will be deemed that the employee accepted the offer and has waived the right to object to the location or shift.

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.

First Name MI

Last Name

Claim Number

Date Offer Received MM/DD/YYYY

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

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

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%.

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.

_____ Date _____

(Signature) MM/DD/YYYY