

BONA FIDE OFFER OF EMPLOYMENT

(The Employer) makes this modified offer of employment in compliance with the Texas Department of Insurance, Division of Workers' Compensation (Division) Rule 129.6. This offer of employment is made to the employee in writing and in the form and manner prescribed by the Division. (The Employer) attaches a copy of the Work Status Report (DWC-73), which is the basis for this offer of employment. (The Employer) values its employees and will work diligently to bring its employees back to work. (The Employer) will only assign tasks consistent with the employee's physical abilities, knowledge, and skills and will provide training if necessary.

The employee's name and address

(Please insert all appropriate information)

The employee's job title, job duties and job description the employer now offers

(Please insert all appropriate information)

The location at which the employee will be working

(Please insert all information on location)

The schedule the employee will be working

(Please insert all information on the employee's schedule)

The wages that the employee will be paid

(Please insert all information regarding the employee's wages)

A description of the physical and time requirements that the position will entail

(Please insert all information regarding the employee's physical and time requirements)

The modified duty offer is geographically accessible

(Please insert all information that makes this offer geographically accessible for this employee)

The modified duty offer is consistent with the doctor's certification of the employee's work abilities

(Please insert all information regarding consistency with the doctor's certification)

The modified duty offer is communicated to the employee in writing

(Please insert all information to show this was communicated to the employee in writing)

If you refuse to accept this offer of employment or you do not respond to this offer, the Insurance Carrier may reduce your workers compensation indemnity benefits based on this offer of employment. However, you will still be entitled to medical benefits for reasonable and necessary medical treatment. You have the right to request a benefit review conference relating to this offer of employment.

If you have any questions, concerns or suggestions about this offer of employment, please feel free to call (The Employer), its insurance carrier (name of insurance carrier) and/or its third party administrator (name of third party administrator), if any. We can assist you with any questions you may have.

Sincerely,

Signature of Employer Representative

Title of Employer Representative

Attachment: Work Status Report from Dr. (insert doctor's name) dated (insert the date on Work Status Report)

_____ [☐] I accept the modified duty employment offer as stated above under these provisions.

_____ [☐] I decline the modified duty employment offer as stated above under these provisions for the following reasons:

Employee's Signature: _____

Employee's Name (please print): _____

Date Signed by Employee: _____

Employer's Representative: _____

Employer's Representative (print): _____

Date Received by Employer: _____