EMPLOYER TRANSITIONAL/ PERMANENT JOB OFFER

WSI
North Dakota Workforce Safety & Insurance

CLAIMS DIVISION
SFN 58355 (04/2022)

SECTION 1 – *Injured employee's information*

Claim number	Injured employee's (First name)	(Last name)

Employer's name

Employer's address

SECTION 2 – *Job details*

The medical provider has released this injured employee to return to work with the following restrictions

The job offer is
☐ Transitional   ☐ Permanent

Job title

Duties include

List any accommodations

Return to work date	Hours of work		Rate of pay
	per day	per week	per hour

Your medical provider has approved this position as being physically appropriate. The duties outlined above will need to be performed within your restrictions, otherwise you will need to request assistance, if needed, to perform specific tasks.

Reassignment to another department might be needed if duties are not found within the medical provider's recommendations. Notify your immediate supervisor if there are any problems in performing assigned duties. It is your responsibility to notify your supervisor if time off is requested. If working in a different department, notify the immediate supervisor of that department regarding any modifications to your work schedule. Failure to accept a modified or alternative position that is approved by a medical provider may result in termination of wage loss benefits.

SECTION 3 – *Signature*

Return this form to your employer by _____ indicating whether you will be returning to work. If you do not respond within the time indicated above, it means that you agree the job outlined above is appropriate, but you do not wish to accept the job and you are terminating your employment with us.

☐ I accept the position

☐ I do not accept the position

Injured employee's signature	**Date**

Employer's signature	**Date**

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