



**EMPLOYER TRANSITIONAL/
PERMANENT JOB OFFER**
CLAIMS DIVISION
SFN 58355 (04/2022)

1600 E Century Ave, Ste 1
PO Box 5585
Bismarck ND 58506-5585
Telephone 800-777-5033
Toll Free Fax 888-786-8695
TTY (hearing impaired) 800-366-6888
Fraud and Safety Hotline 800-243-3331
www.workforcesafety.com

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 per day per week	Rate of pay 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