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March 8, 2018

Employee Name

Employee Address

City, State Zip

**RE: Bona Fide Offer of Employment (BFOE)/Transitional Duty Assignment**

**Date of Injury:** Click here to enter a date **Claim #:**  Enter claim #

Dear Employee Name,

This letter will serve as our offer of a Transitional Duty Assignment that meets the physical restrictions imposed by a medical provider. I have attached a copy of the medical report (Enter Title of medical report ie: DWC73) from Doctor’s Name for visit on Enter Date of visit upon which this offer is based. The Transitional Duty Assignment being offered to you will not exceed the restrictions stated in the attached medical report.

You are being offered a Transitional Duty assignment at Location and Physical Address beginning If offer is accepted by phone = next scheduled work day. If offer extended by mail = next scheduled work day after 13 calendar days from date mailed and continue for a possible Enter # of Transitional Duty days approved and/or remaining days or until you are released by your doctor to full duty. You will be earning the same hourly and weekly rate of pay,0.00 per hour and 0.00 per week. This Transitional Duty Assignment is for # of hours hours per week # of hours hours per day, # of days days per week. We are asking that you report to work enter first day of week, at start time through last day of week and end time.

The City will only assign tasks consistent with your physical abilities, knowledge, and skills and will provide training if necessary. This assignment will not require you to exceed the restrictions as stated on the medical report (Enter Title of medical report ie: DWC73) from Doctor’s Name for visit on Enter Date of visit.

This Transitional Duty Assignment requires you to perform the following tasks:

 Enter transitional duty assignments such as keyboarding, shredding, answering phones for approximately # of hours or percentage of day

The restrictions are: Enter restrictions such as those found in Part III of the DWC73.

You will report to Name of supervisor or their designee and they can be reached at Supervisor’s telephone number .

During this Transitional Duty Assignment, you will be required to attend any and all medical appointments as prescribed by your treating physicians. You will be responsible for your own transportation to and from all medical appointments.

If you have any questions during your assignment, please direct them to Name of DDR your Designated Department Representative at DDR’s phone number.

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Designated Department Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BFOE and Enclosure Delivered By

Should you **ACCEPT** this Transitional Duty Assignment, you will begin work on Enter beginning date from Paragraph 2 on page 1.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Accepted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employee’s Signature

Should you **DECLINE** this Transitional Duty Assignment; you are subjected to loss of benefits.

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 Employee’s Signature

Enclosure: Medical report (Enter Title of medical report ie: DWC73) from Doctor’s Name for visit on Enter Date of visit (Employee to initial receipt of medical report)

Cc: Adjuster