



Injured worker name	Claim number
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- The employer agrees to employ the injured worker as an employee with all the rights, privileges and responsibilities of all other similarly situated employees, with employment as \_\_\_\_\_.
- This employment is to begin on \_\_\_\_\_. The full gross wage to be paid to the injured worker is \$ \_\_\_\_\_ per hour or \$ \_\_\_\_\_ per week. BWC shall reimburse the employer for a portion of the injured worker's wages according to the distribution below.

Number of weeks	Period of reimbursement		Employer contribution		BWC contribution		
			%	Amount paid	%	Amount paid	
	From:	To:					
	From:	To:					
	From:	To:					
	From:	To:					
	From:	To:					
	From:	To:					
<b>Total weeks</b>			<b>%</b>	<b>Total paid</b>		<b>%</b>	<b>Total paid</b>

- Any time the injured worker works more than \_\_\_ hours per day or \_\_\_ hours per week, the employer will pay compensation for such hours.
- Reimbursement of incentive monies can only occur when BWC receives documentation of gross wages (i.e. signed payroll records) paid to the injured worker for the applicable reimbursement period.
- The employer understands that BWC's reimbursement for the employment or re-employment of the injured worker is a discretionary function of BWC.
- This agreement shall be in full force and effect until canceled by the employer or revocation of approval by BWC with 10 days written notice to all parties, or upon the termination of the injured worker's employment.

Warning: Any person who obtains compensation benefits from BWC or self-insuring employers by knowingly misrepresenting or concealing facts, making false statements or accepting compensation or benefits to which he/she is not entitled, is subject to felony criminal prosecution for fraud.

Authorized employer name			
BWC policy number	FEIN		
Address	City	State	Nine-digit ZIP Code
Employer representative signature (Name and title)			Date
Injured worker signature			Date
Vocational rehabilitation case manager signature			Date