



Instructions

- Please print or type.
- Make sure to enter four digits for the year in all date fields.
- **Case manager** follow the distribution list at the bottom.

Injured worker name	Claim number
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1. 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 _____ .
2. This employment is to begin on _____. The full gross wage to be paid to the injured worker is \$_____ per hour or \$_____ per week. Due to the injured worker's initial adjustment period, BWC agrees to 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:				
Total weeks		%	Total paid	%	Total paid

3. Any time the injured worker works more than _____ hours per day or _____ hours per week, the employer will pay compensation for such hours.
4. 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 contracted reimbursement period.
5. The employer understands that BWC's offer of reimbursement in this contract, for the employment or re-employment of the injured worker, is a discretionary function of BWC.
6. This agreement shall be in full force and effect until canceled by either the employer or BWC with 10 days written notice to each of the other parties or upon the termination of the injured worker's employment.

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

Authorized employer name			
Address	City	State	9-digit ZIP Code
Employer representative signature (Name & Title)			Date
Injured worker signature			Date
Vocational rehabilitation case manager signature			Date

Distribution: BWC claim file, injured worker, injured worker representative, employer, employer representative