GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE TO EMPLOYEE OF OFFER OF SUITABLE EMPLOYMENT

Instructions: The employer shall use this form to notify an employee of an offer of employment which is suitable to his/her impaired condition, as required by O.C.G.A. ! 34-9-240 and Board Rule 240. This form, with all attachments, must be provided to the employee and counsel for the employee at least ten days prior to the date the employee is expected to return to work. This form, along with attachments, should only be filed with the Board as an attachment to a Form WC-2.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	SSN or Board Tracking #	Date of Injury

A. IDENTIFYING INFORMATION

EMPLOYEE	County of Injury	Address		
Employee E-mail		City	State	Zip Code
EMPLOYER	Name	Address		
Employer E-mail		City	State	Zip Code

B. NOTICE TO EMPLOYEE

1. This is to inform you that the following job is being made available to you pursuant to the requirements of O.C.G.A. ! 34-9-240 and Board Rule 240 (b):

Title	
Essential Duties (Attach Additional Pages as needed)	
Rate of Pay	Location of Job
Hours / Days to be Worked	Date / Time to Report for Work

2. A copy of the report(s) of your authorized treating physician(s), approving the job as suitable to your condition, is / are attached.

3. If you unjustifiably refuse to attempt to perform the job offered after receiving this notification or if you attempt the job for less than eight cumulative hours or one scheduled work day, whichever is greater, the employer/insurer shall be authorized to suspend payment of income benefits to you effective the date you are scheduled to report to work. Should you attempt but fail to continue working for fifteen (15) scheduled work days, your income benefits shall immediately be reinstated.

4. If you have any questions about the job being offered to you, you may contact the employer at: _____ .

C. CERTIFICATION

0 I hereby certify that the above-named job is available to this employee as outlined above, that the job duties have been approved by the authorized treating physician(s) who has examined the employee within 60 days of the attached approval, and that this offer is being made in good faith no later than ten days prior to the date the employee is expected to report for work. I further certify that I have this day sent a copy of this form to the employee and counsel for employer (if represented.)

Print Name / Title Here	E-mail	Address		
Signature	Date	City	State	Zip Code

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. ! 34-9-18 AND ! 34-9-19).