



Bona Fide Offer of Employment Memorandum

Print Form

Risk Management
Mat-Su Borough School District
501 N. Gulkana
Palmer, AK 99645
P (907) 746-9213 || F (907) 761-4091

TO: ID #

FROM:

SUBJECT: Bona Fide Offer of Employment (BOE)

Today's Date <input type="text"/>	Date of Injury / Illness <input type="text"/>	Is the Injury/Illness a result of a Worker's Compensation Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	Department Representative: This form must be sent through certified mail if employee is unavailable for signature. <input type="text"/>
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After reviewing the information provided by your physician, we are pleased to offer you the following temporary work assignment as part of the Mat-Su Borough School District's Early Return to Work Program. You may obtain a copy of the Early Return to Work Program from your supervisor or download a copy on the [Risk Management Forms Page at http://www.matsuk12.us/](http://www.matsuk12.us/). Training will be provided for this assignment where required.

Description of Physical Requirements of this Position: Per attached medical information provided by the physician (e.g., MSBSD Early Return to Work Program - Work Status Report, Certification of Physician or Practitioner Form, or other medical information).

Job Title Location

Job Tasks

Duration of Assignment (max. 45 calendar days per injury/illness)* Begin Date End Date

Scheduled Hours (specify a.m./p.m.) Days Mon. Tues. Wed. Thur. Fri. Sat. Sun.

Pay Rate Hourly Daily Supervisor Phone

Notes

Family Medical Leave Act (FMLA) Information: If you are eligible for FMLA and have not used 12-workweeks of FMLA during this fiscal year, you may choose to decline this offer and utilize FMLA job protection. If you are eligible for FMLA and choose to accept this BOE and it is for reduced work-hours due to the restrictions placed on you by your physician, the time you are not at work will count towards your available FMLA balance.

Workers' Compensation Insurance (WCI) Information: If your injury is covered by WCI, refusal of this job offer may impact your Temporary Income Benefit payments.

This job offer will remain open for two (2) workdays from your receipt of this memorandum. We will determine that you have refused this job offer if you have not responded to us within two (2) business days of your receipt of this letter. We look forward to your return to work. If you have any questions, please contact us at (907)746-9213.

*** Additional Stipulations of your Assignment:**

1. This temporary assignment will be reviewed on unless medical documentation is provided sooner indicating the restrictions of your medical condition have changed or you are otherwise released to full duty. Your return to work may be delayed if you do not provide your department with sufficient medical information in a timely manner.
2. Management may place you on appropriate leave during this temporary work assignment if viable duties can no longer be identified.

SUBMIT FORM TO: Risk Management

T: (907)746-9213 || F: (907)761-4091 || Nicole.Lundstrom@matsuk12.us || 501 N. Gulkana; Palmer, AK 99645



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EXISTING RESTRICTIONS:

Affected Body Part

Limited Duty with the Following Minimal Restrictions:

- No Lifting over pounds from through
- No Repetitive Lifting over pounds from through
- No Prolonged Sitting from through
- No Prolonged Standing from through
- No Excessive Bending or Twisting from through

Other Restrictions / Comments (Include Dates)

GRANTED ACCOMMODATIONS:

EMPLOYEE ACKNOWLEDGEMENT (Check one):

I, the undersigned, have been advised that medical restrictions have been placed on my activities while performing duties within the scope of my employment. I have read and understand the medical restrictions as detailed above. I further understand that it is my responsibility not to violate these restrictions. I further understand and agree that if a supervisor requests that I perform duties that would violate these restrictions, I will immediately advise that supervisor and other management, if necessary, of my restrictions.. **I further agree to keep my scheduled doctors appointments and keep my advisor informed in the event my doctor changes these restrictions.**

I **accept** **decline** the above offer of employment.

Employee Signature Date

OR, the employee has failed to respond to this letter.

Signed (Supervisor or Designee) Date District Representative Signature Date

Distribution: (1) Original - Employee (2) Copy - Risk Management (3) Copy - Human Resources