



Employer _____

Worker's job title:

Worker _____

WCD no.: _____
(from front of preferred worker card)

Total agreement amount: \$

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CONDITIONS OF THIS AGREEMENT

The employer will:

- 1) Maintain Oregon workers' compensation insurance coverage as long as the employer is a subject employer as defined by ORS 656.023.
- 2) Employ the worker according to the same business practices, policies, and agreements affecting all other employees.
- 3) Repay all costs incurred by the Workers' Compensation Division (WCD) under this agreement, including all legal costs and attorney fees, if WCD finds the employer falsely obtained re-employment assistance or if WCD subsequently prevails in any legal action against the employer arising out of this agreement.
- 4) **If you are the employer at injury, submit a job offer letter signed by the worker with this request.** (To see an example of Preferred Worker Job Offer Letter, Form 4903, go to <http://wcd.oregon.gov/forms/Pages/forms.aspx>.)

The worker will:

- 1) Follow the same business practices, policies, and agreements affecting all other employees of same employer.
- 2) Be subject to sanctions under OAR 436-110-0900 if the worker has knowingly misrepresented information or otherwise falsely obtained assistance under this agreement.
- 3) If this is a pre-employment agreement, use purchases to find a job.

The Workers' Compensation Division reserves the right to:

- 1) Pay only for items purchased under this agreement.
- 2) Visit the worksite and inspect and copy employer records to verify employment of the worker and otherwise determine compliance with this agreement.
- 3) End this agreement at any time by written notice to the employer and the worker.

We hereby certify that the items listed in this agreement are required for the worker to find a job, or to perform a job for which the worker is being employed, and are not provided by the employer. We understand that these employment purchases will become the worker's property, and that WCD has no liability for injuries or damages caused by any employment purchase.

Worker signature*

**Not required if initiated by employer at injury*

Date

Employer signature*

**Not required if not employed*

Date

After signing this agreement:

Fax to 503-947-7581 or

Mail to Preferred Worker Program, P.O. Box 14480, Salem, OR 97309-0405

This agreement is not valid until signed by an authorized representative of the Workers' Compensation Division.

WCD USE ONLY		Data entry
Maximum approved under this agreement \$ _____		
Effective date: _____ End date: _____		
Program approval _____ Date _____		