

RETURN-TO-WORK PROGRAM

Scope and Application

This policy applies to all locations or projects where a Return-to-Work Program may need to be implemented.

It is our goal to return employees, who have sustained a compensable injury, back to work as soon as possible.

Our Return-to-Work Program is developed to provide employees, who cannot return to their regular job, with modified/transitional duty during their medical recovery period. Modified/transitional duty is temporary work that is within the employee's physical abilities, knowledge, and skills. Employees with accepted disabling workers' compensation claims are eligible for this program. The Return-to-Work program will involve coordination by the injured employee, Workers' Compensation Claims person, the treating physician, and your insurer.

Implementation

It is the responsibility of management to administer the organization's Return-to-Work program. It is the responsibility of any employee or contractor involved to adhere fully to this policy.

Procedures

1.0 Return-to-Work Procedures:

- A. The employee's supervisor is to be contacted immediately if there is any incident, regardless of the magnitude.
- B. When a supervisor is notified of a work related injury, he/she should review the "Report of Injury Employee Responsibilities Checklist" with the employee.
 1. A first report of injury is completed and sent to the insurer. (If applicable by jurisdiction, for example in Washington State, the attending physician completes the "First Report of Injury".)
- C. If immediate medical treatment is indicated, medical care from the appropriate medical facility by the most effective means will be provided.
 1. When possible, the employee should take a "Return-to-Work Evaluation" to the physician for completion.
 - a) If the employee cannot take the evaluation, the name of the physician should be obtained and a copy forwarded to the physician immediately.
 2. If a job description for proposed modified/transitional duty and regular job description are available, this should also be sent.
 3. The employee should provide his or her supervisor with a completed "Return-to-Work Evaluation" after every visit to the treating physician.

RETURN-TO-WORK PROGRAM

- D. If the job description was not previously provided to the treating physician, the "Return-to-Work Evaluation" should be reviewed by the employer contact.
 - 1. A modified/transitional duty position should be considered that is within the employee's physical capacities.
 - 2. If work is available which meets the limitations/ restrictions set forth by the attending physician, the employee may be assigned modified/transitional work which will not exceed ninety (90) days.
 - a) A job description will be developed and provided to the treating physician by the employer contact for approval.
- E. When the treating physician has approved the job description, a job offer letter will be sent to the employee by certified and regular mail.
 - 1. The job offer letter will include a copy of the signed job analysis, a copy of the physician's release for work, the date to report to work, whom to report to, where to report, time to report, wages, hours and duration of modified/transitional duty.
 - 2. The employee will be asked to indicate whether the job is accepted or declined and so indicates with a signature.
 - a) This information should be forwarded to the insurer after completion.
- F. If an employee chooses not to participate in the modified/transitional duty program due to a work-related injury or illness, he/she may become ineligible for worker's compensation time-loss benefits.
- G. When the employee reports to modified/transitional duty, the employer contact should carefully review the job approved by the physician.
 - 1. The restrictions should be reviewed.
 - a) The employer contact should emphasize that the employee should perform only the job duties within the treating physician's restrictions and within the job description approved by the treating physician.
 - b) This needs to be monitored to assure compliance and improvement of the person.
 - 2. It is the employee's responsibility to keep the company apprised weekly of their status after each physician visit.
- H. Modified/transitional duty is a temporary program and an employee's eligibility in a temporary assignment will be based on medical documentation and continued recovery of the employee and the ongoing needs of the employer.
 - 1. Although transitional work is not guaranteed, transitional duty will be available on a fair and equitable basis with the temporary assignment being based on skill, abilities and restrictions as well as the needs of the department.
- I. The employer contact will monitor the employee's recovery progress and participation.
 - 1. The employer contact will also be responsible for tracking the hours worked.

RETURN-TO-WORK PROGRAM

- a) Every effort will be made to coordinate a restricted work schedule with the employee's normal work schedule.
- b) Dependent upon the employee's limitations/restrictions, it may be necessary to design a temporary schedule to accommodate the restrictions that may not match the employee's normal schedule.
- 2. In the case of reduced work hours, Family Medical Leave may be applied to the hours not worked.
- 3. Contact Human Resources for further details.
- J. Any change in the original modified/transitional duty job must be reviewed by the employer contact and approved by the physician.
 - 1. A new job offer letter will be sent and signed by the employee.
- K. Employees must provide a "Return to Work Evaluation" form indicating they are capable of returning to full duty.
 - 1. Permanent job restrictions will be evaluated on a case-by-case basis and relate to the performance of the essential functions of the job.
 - 2. No permanent light duty positions will be created.

2.0 Documentation Summary:

- A. The Risk Management Center is to be used to document all information including the following:

Documents	Risk Management Center Location
Return-to-Work Program	My Content™
Training Documentation including: <ul style="list-style-type: none">- Classroom training and training course completed- Sign-in sheets- Quizzes- Skills evaluations- Operator Certificates	Training Track™ application
Pre-shift Inspection Checklists	My Content™
Safety Observations	Job Hazard Analysis/ Safety Observation Tool™
Near misses	Incident Track™
Accidents and claims	Incident Track™
Supplier and manufacturer Certificates of Insurance	COI Track™
Safety Data Sheets	SDS Track™

RETURN-TO-WORK PROGRAM

Appendix A: Report of Injury - Employee Responsibilities Checklist

- All work-related accidents, injuries, and near misses must be reported immediately to [enter department] supervisor.
- If an incident such as an injury or near miss occurs, but does not require professional medical treatment, the supervisor must be informed immediately and an incident report must be completed. If necessary, the employee may receive first aid on-site.
- If an injury occurs which requires medical attention, the employee will follow the emergency response plan. The employee must fill out a Workers' Compensation First Report of Injury form as soon as possible.
- If medical attention is sought, the employee should inform the physician, that [Company Name] has a return-to-work program with modified duty jobs available.
- The employee should be given a "Return-to-Work Evaluation Form" and completed "Job Description" (if available) from [enter department] supervisor. This should be given to the treating physician and should be returned to [enter department] supervisor following the initial medical treatment.
- If the treating doctor releases the employee to return to modified duty, as indicated on the "Return-to-Work Evaluation Form" and "Job Description Form", both forms must be returned to [enter department] within 24 hours for a modified duty work assignment. The employee must report for work at the designated time. The employee may not return to work without a release from the attending doctor.
- If the employee returns to a modified duty job, they must perform within the limits of the duties of the job, or their treating doctor's restrictions. If at any time, job restrictions change the supervisor is to be notified immediately, and provided with a new medical release from the physician.
- If after treatment, the employee is unable to report for any kind of work, the employee must call their supervisor each week to report their medical status.
- It is the responsibility of the employee to supply [enter department] supervisor with a current telephone number and an address where the employee can be contacted while not working.
- The employee will notify their [enter department] supervisor within 24 hours of all changes in medical condition.

I have read and understand the above information.

Employee Signature_____ Date_____

RETURN-TO-WORK PROGRAM

RETURN-TO-WORK PROGRAM

Appendix B: Request for Return-to-Work Evaluation from Treating Physician

(Type on Company Letterhead)

Date

Physician's Name

Address

City, State, Zip

RE: Injured Employee:

Date of Injury:

Employer:

Dear Dr. [REDACTED]:

We appreciate your prompt treatment of our employee. We have an Early Return-to-Work Policy. In an effort to return our employee to work we would like you to complete the attached "Return-to-Work Evaluation". We can provide modified/transitional duty from the sedentary range up to modifications of the employee's regular position.

Once we have reviewed the completed Early Return-to-Work Evaluation, we will provide a job analysis that is within the employee's physical capacities for your review. We will then make a job offer to our employee.

We appreciate your concern for our employee and look forward to your response. Feel free to contact us if additional information is needed.

Sincerely,

Employer contact

[enter phone number]

RETURN-TO-WORK PROGRAM

Appendix C: Return-to-Work Evaluation Form

Patient _____ Date of Injury _____

Employer _____ Claim Number _____

1. In an 8 hour day, patient can stand / walk:
_____None _____1-4 hrs. _____4-6 hrs. _____6-8 hrs.

2. In an 8 hour work-day, patient can sit:
_____1-3 hrs. _____3-5 hrs. _____5-8 hrs.

3. Patient can lift:
_____Up to 10 lbs. _____10-20 lbs. _____20-50 lbs.

4. Lifting as indicated in item 3 can be performed during the work day:
_____Occasionally _____Frequently _____Continuously

5. Patient can use hands for repetitive:

a. Simple grasping	b. Pushing and pulling	c. Fine manipulation
____Yes ____No	____Yes ____No	____Yes ____No

6. Patient can use feet for repetitive movement as in operating foot controls:
_____Yes _____No

7. Patient is able to:	Frequently	Occasionally	Not at All
a. Bend	_____	_____	_____
b. Squat	_____	_____	_____
c. Climb	_____	_____	_____

8. Confirm number of hours patient can perform duties:
_____2 hrs. _____4 hrs. _____6 hrs. _____8 hrs.

9. Other restrictions as indicated by the doctor:

10. Anticipated date for release to regular work:

Physician's Signature: _____ Date: _____

Print Physician's Name: _____

RETURN-TO-WORK PROGRAM

Appendix D: Job Description

Employer Address _____

Employee Address _____

Phone/Fax Nos. _____ Phone No. _____

Contact Person _____ Claim No. _____

SS# _____ Job Title _____

Duration _____

Job Duties:

Appendix D: Job Description (continued)

RETURN-TO-WORK PROGRAM

ENDURANCE

Hours at one time

Sit 0
Stand 0
Walk 0

Total hours in an 8-hour day

0
0
0

PHYSICAL

Lift	Never 0%	Occas. 33%	Freq. 45- 66%	Cont. 67- 100%		Never 0%	Occas. 33%	Freq. 45- 66%	Cont. 67- 100%
1 to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 75	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76 to 100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Walk-level surface	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carry					Walk-uneven surface	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climb stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climb ladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reach above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 75 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive use arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76 to 100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repetitive use wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Repetitive use hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Push					(a) Grasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(b) Squeezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Operate foot control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
51 to 75	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
76 to 100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Environment				
					Inside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pull					Outside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1 to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dusty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 75	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Noisy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
76 to 100	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RETURN-TO-WORK PROGRAM

Appendix D: Job Description (continued)

PHYSICIAN'S

COMMENTS: _____

Job Appropriate Yes ☐ No ☐

Date of

Release _____

EMPLOYER SIGNATURE

DATE

PHYSICIAN'S SIGNATURE

DATE

Appendix E: Modified Job Description Letter

RETURN-TO-WORK PROGRAM

(Type on Company Letterhead)

Date

Physician's Name

Address

City, State, Zip

RE: Injured Employee:

Employer:

Claim #:

Date of Injury:

Dear Dr. [enter doctor name]:

Thank you for providing the current work restrictions for our employee, [enter injured employee's name]. We have attached a copy of a modified job description that is within the restrictions that you have provided. Do you feel [enter employee name] is capable of performing the attached job as described?

Yes_____ No_____

Signature_____ Date_____

If he/she is not capable of performing this job please provide an explanation of job duties that should be further modified.

Comments_____

Thank you in advance for your time and consideration in this matter. We look forward to your prompt response.

Sincerely,

Name

Title

RETURN-TO-WORK PROGRAM

Appendix F: Injured Employee Letter

(Type on Company Letterhead)

Date

Name:

Address:

City:

RE: Claim No.:

Date of Injury:

Dear [enter injured employee's name],

Your treating physician has released you for modified work and has approved the attached job of [enter job title].

You will receive \$ [enter rate] per hour. We will supplement your worker's compensation benefits if this salary is less than your average weekly wages.

Information regarding your modified job is listed below:

Date:	Supervisor to report to: _____
Time:	Hours per day/week: _____
Location:	Duration of modified job: _____

If you receive this letter after the report to work date, please contact [enter name of supervisor] at [enter phone number] immediately.

Your benefits may be adversely affected if you choose not to accept this modified job offer.

We look forward to your return to work on the above date.

Sincerely,

[enter name, title, phone no.]

I have read and understand the above information. I accept the above job as offered.

YES **NO** (circle one)

Employee's Signature

Date