

## Appendix A - Sample program 1

### **SAMPLE RETURN-TO-WORK PROGRAM**

This program is to minimize the production lost by the company and wages lost by the employee as a result of temporary partial incapacity resulting from on the job injury. It is the express intent to provide modified duty within the employee's restrictions whenever possible and to facilitate the employees full rehabilitation as rapidly as possible.

The Human Resources Director is primarily responsible for administration of this procedure.

#### I. Notification of Restriction

- A. Human Resources will be notified that an employee has been injured.
- B. Copy of completed Treatment Report will be furnished to Human Resources immediately after treatment; if after office hours, a copy will be left in the Supervisor's office and furnished to Human Resources the next business morning.
- C. In the event the injured employee cannot return to the facility due to hospitalization or similarly severe prescribed restriction, Human Resources will obtain required information directly from the medical resources.
- D. The Treatment Report is the primary document to capture the treating physician's restrictions. Additional clarification or modification of restriction may be provided on other documents; however, a Treatment Report will be taken by the employee to all medical appointments (except physical therapy).
- E. Restrictions addressed by this policy must be identified by a medical doctor or other state licensed practitioner of the healing arts.

#### II. Identification of Modified Duty Job Assignment(s)

- A. In cases where an employee's restrictions preclude performing his pre-injury job (or particular aspect of the job), every reasonable effort will be made to identify or create a productive job assignment which will accommodate temporary restrictions as identified by the treating physician.
  1. This accommodation may include providing intermittent assistance or relief in dealing with one or more elements of the employees "regular" (pre-injury) job.
  2. Accommodation may also include arrangements for less than an eight hour work day (in such cases, hours not worked will be accumulated and submitted to the worker's compensation insurance carrier).
  3. Every effort will be made to place the employee in the most productive assignment available; direct labor categories will be preferred over indirect.
  4. The modified duty job assignment will be made by the Human Resources Director after consultation with production management.

- B. The modified duty job assignments will be recorded on the Restricted Job Description, to be completed by Human Resources prior to or coincidental with the employee's return to work.
1. The Description will be acknowledged by the employee, supervisor, union representative and the Human Resources Director. Each will be provided a copy of the completed document.
  2. The Description may be revised or reissued based on change in the employee's restrictions. The Description will expire 90 days after last authorization or when employee is released without restrictions.
  3. It is the Supervisor's explicit responsibility not to assign any work to the employee which is contrary to the identified restrictions. The employee has an explicit responsibility not to attempt any task which may exceed his identified restrictions. Any difficulties experienced by the employee within his restrictions will be reported to Human Resources for review with treating physician.
  4. Any questions or controversy as to an employee being restricted from performing specific task(s) will be brought to the immediate attention of the Human Resources Director for resolution.
  5. The Human Resources Director will notify all parties when the employee has been fully released for unrestricted duty.
- C. Wages and Related Considerations
1. The employee will continue to receive his/her pre-injury wage, plus any general increases, for all hours worked in a restricted capacity.
  2. The employee will be paid per C.1 for hours less than his/her scheduled shift lost due to company arranged examinations, treatment and therapy.
  3. The employee may not bid on any posted job openings while in a restricted capacity.
  4. The employee will be shown on the weekly schedule as "restricted."

Since he will "follow the work" within restrictions, normal shift scheduling practices may not be possible

## **SAMPLE RETURN-TO-WORK POLICY**

It is the purpose of this policy to provide guidelines for administering a modified duty program. This program is necessary to limit the amount of lost workdays an injured or ill employee may incur by providing meaningful work of a restricted or limited nature. The program objectives should prevent the unnecessary loss of work time for valuable employees and help maintain continuity of departmental operations to the maximum extent possible.

### **Definitions:**

#### **Restricted Duty**

Duties assigned to an injured or industrially ill employee which enable the employee to retain his/her current status with some limited restrictions and with the company being able to make a reasonable accommodation of full duties.

#### **Alternate Duty**

Duties assigned to an injured or industrially ill employee which require the employee to transfer to another job position or department on a temporary basis.

#### **Work Related**

Any injury or illness which occurs while performing assigned job duties.

### **Responsibilities:**

#### **Injured Employee**

1. Have any or all specific job-related restrictions approved by company designated physicians, as necessary.
2. Report all job-related restrictions to the Safety Director and your immediate Supervisor.
3. Keep both the Safety Director and immediate Supervisor informed of any change in job-related restrictions.
4. Adhere to all medical advice and directives as prescribed by your treating physician, nurse, or other medically qualified professional.
5. Question any medical directives which you may not understand.
6. Do NOT perform any activity which is not in accord with your job-related restrictions, both on and off the job.
7. Employees must be re-evaluated by a company designated physician within 30 days of their last examination to determine whether their modified duty status should be continued.

NOTE: Failure to adhere to any work-related restrictions may result in disciplinary action.

### **Supervisors**

1. Insure all employees with job-related restrictions are adhering to their restrictions as noted on the modified duty form.

2. Assign employees with job-related restrictions to jobs which can accommodate their restrictions. If no jobs are available within your department, contact the Human Resources Department and/or the Safety Director to discuss options or arrange for departmental transfer.
3. Compile and maintain a list of departmental job duties that meet light duty requirements. List to be given to Human Resource/Safety Department.

### **Human Resources/ Safety Department**

1. Arrange for temporary work assignment of modified duty employees where no work is available within the employee's regular department.
2. Contact all Company designated physicians and inform them of our modified duty policy. Provide periodic updates and any change of status relating to the modified duty program.
3. Schedule all employees re-evaluations as noted in the "Injured Employees Responsibilities" number seven.

### **Guidelines**

1. Restricted duty employees will be compensated at their designated base rate for a period not to exceed 4 weeks for work-related injuries. For non-work related injuries, the employee will be compensated at the rate of pay, by contract, for the job he/she is performing. After 4 weeks, the Human Resources/Safety Department will determine the rate of pay for the job being performed. At no time will the rate of pay be less than labor rate per contract.
2. Alternate duty employees, with a work related injury, will be compensated at their designated base rate for a period not to exceed 4 weeks. For non-work related injury, the employee will be compensated at labor rate per contract. After 4 weeks, the Human Resources/ Safety Department will determine the rate of pay for the job being performed. At no time will the rate of pay be less than labor rate per contract.
3. Job availability for work related injuries will take precedence over non-work related injuries.
4. The company shall make every effort to bring people back to work as long as this person can not cause any harm to themselves, others, or company property.
5. A non-work related injured employee may continue on a modified duty job for a period 4 weeks. After this time, they may be placed on or returned to sick leave at the company's discretion.
6. Whether an employee should be continued on modified duty due to a work related injury or illness shall be at the discretion of the company.
7. NO alternate duty employee will be permitted to work overtime.
8. People on modified duty may be assigned to work on any shift at the discretion of the company.
9. Any person who is unable to report for work due to an injury or industrial illness must check in with the company at least once per week. This person shall contact the Human Resources/Safety Department to verify there has or has not been a change in their status as to coming back to

work.

Non Work related injury/illness - Human Resources

Work related injury/illness - Safety Director

10. The company maintains the right to assign employees on modified duty to any job, within the plant, that will not exceed their restrictions and they are capable of doing.

## Appendix A - Sample Program 3

### **SAMPLE RETURN-TO-WORK PROGRAM**

**Purpose:** To provide temporary, modified-duty for members who are partially disabled due to work-related injuries. Every effort will be made to assist the member to return to his/her former position. We will cooperate with the member, the physician, the therapist and any rehabilitation personnel involved in the case.

**Scope:** XYZ Company will provide temporary transitional duty whenever possible for a period of 120 calendar days to determine the degree of improvement. An extension in excess of 120 days may be allowed on a case-by-case basis, when recovery is incomplete. Such extensions will be reviewed every 30 calendar days thereafter and modified work may continue to be provided in cases where improvement continues.

If a member does not demonstrate progress in their recovery through the modified duty program, the program will be reevaluated utilizing the team approach and possibly discontinued as with any other ineffective medical treatment.

Program Coordinator. The Health/Safety Manager will coordinate the return-to-work modified duties with the injured worker, the supervisor and other team members.

#### **OBJECTIVES**

1. To allow the member to remain in the work force and resume productive employment as soon as possible in his/her normal classification.
2. To enable the worker to gradually overcome his/her limitations through a transitional period of modified-duty, work reconditioning assignments.

#### **TYPE OF WORK**

1. All departments at XYZ Company will cooperate in every way possible to provide regular duties on a limited basis, modified duty and/or special assignments for the disabled member. Whenever possible, attempts will be made to allow the member to remain in his/her classification with modified duties.
2. Some of the following special assignments and/or modified duties in addition to regular duties might include:
  - Rework (sort rejected parts)
  - Clerical work
  - Visitor escort
  - Label and file samples
  - Errands in company vehicle
  - Light janitorial duties

- Engage in physical reconditioning program
  - Inventory recorder
  - Log and maintain quality records
  - Painting tools
  - Library filing
  - Operate photocopy machine
3. The XYZ Company Occupational Health Nurse will supervise all members undergoing rehabilitation and/or modified duty. When these members are assigned to their regular departments, they will report to the supervisor in that department under the direction of the Occupational Health Nurse. Members undergoing rehabilitation who are not working in their regular departments will be given assignments by the Occupational Nurse.
  4. On evening, night shifts and weekends, modification of job duties may be made at any time by the supervisor of a member who has reported an injury, until the member sees the Occupational Health Nurse or sees a practitioner on the Workers Compensation panel of providers.

## **SUPERVISION**

Unless on a specific errand, members undergoing rehabilitation will have the same obligation to remain at their designated work station as any other member.

## **DOCTOR'S APPOINTMENTS**

1. The XYZ Company notification policy regarding doctor's appointments will also apply to members undergoing rehabilitation. If the member requires follow-up treatment or a doctor's appointment which cannot be scheduled during his/her non-working time, the Company shall compensate the member for any straight-time lost from work due to said treatment or appointment; provided that the member must have given the Company prompt prior notice that such treatment or appointment could not be scheduled during non-working time, in which case the Company shall have the right to attempt to change the member's treatment or appointment to non-working time and, if able to do so, the member shall not be entitled to compensation if the employee chooses nevertheless to keep the treatment or appointment on working time.

Appendix B - Job Analyses forms

**JOB DESCRIPTION - ESSENTIAL FUNCTIONS**

Job Title:

Essential Functions of the Job:

Physical Demand Classification:

PHYSICAL REQUIREMENTS						
Requirements	% Of Time	Forces / Weights	Repetitions	Distance / Height	Items	Comments
	Occasional 0-33 Frequent 34-66 Continuous 67 +		Occasional 0-32  Frequent 33-200 Continuous 200			
Standing						
Sitting						
Driving						
Walking						
Lifting						
Carrying						
Pushing						
Pulling						
Squatting / Stooping						
Crawling						
Climbing Stairs Ladders						
Reaching Overhead Below						
Kneeling						
Bending Knees Elbows Torso / Back						
Hand Function Close Grasp Pinch Fine Manipulation						

**WORK CONDITIONS**

Noise Level	Inside	Outside	Temperature Changes:
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Working Hazards:	Exposure to Dust, Fumes, Gases:
Tools used for the job:	
Accommodation available:	

Appendix 2 – Restricted Duty Job Description 1

**RESTRICTED DUTY JOB DESCRIPTION**

Position: Modified Duty \_\_\_\_\_

Supervisor: \_\_\_\_\_

**General Description:** Performs restricted duty assignments within the weight and/or physical limitations prescribed by a provider. Employee must be eligible to receive workers' compensation benefits and must have medical release for restricted duty.

**Responsibilities/Examples of Work:**

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**Special Limitations:** The provider's release attached is made a part of this light duty job description, and is to be strictly followed. Failure to follow any portion of these descriptions will be considered a violation of work rules and may result in disciplinary action. Any questions regarding the appropriateness of a work assignment must be brought to the immediate attention of Human Resources.

**Specific Restrictions:**

1. \_\_\_\_\_ lb. lifting restriction
- 2.
- 3.
- 4.

**Time Limit:** The Restricted Duty job description is effective until the employee's next visit to the provider. It may be extended based on the provider's report, however extensions may not exceed ninety (90) days without authorization by Human Resources.

I have read and understand the terms and conditions of the Restricted Duty Job Description. If I have questions I will ask my Supervisor; any differences in interpretation will be brought to the attention of Human Resources.

Date: \_\_\_\_\_ Employee: \_\_\_\_\_

Date: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Date: \_\_\_\_\_ Union: \_\_\_\_\_

Date: \_\_\_\_\_ Human Resources: \_\_\_\_\_

Dr. Appointment: \_\_\_\_\_ With: \_\_\_\_\_

Appendix B – Restricted duty Job Description 2  
**RETURN-TO-WORK PROGRAM**  
**TEMPORARY ASSIGNMENT JOB DESCRIPTION**

**Employee Name:** \_\_\_\_\_ **Hosting Department/Location:** \_\_\_\_\_  
**Position Name:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**Essential Functions:** (Health Care Provider: Indicate if the employee can/cannot perform the essential function listed by circling yes or no. Supervisor: List essential job functions.)

_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No

**Physical Requirements:** ( Supervisor: Check those that apply to job described above. Health Care Provider: Check yes or no)

<b>Requirements</b>	<b>Yes</b>	<b>No</b>	<b>Requirements</b>	<b>Yes</b>	<b>No</b>
___ Lifting			___ Walking	___	___
___ Moderate (15-45 lbs)	___	___	___ Standing	___	___
___ Light (up to 15 lbs)	___	___	___ Sitting	___	___
___ Carrying			___ Crawling	___	___
___ Heavy (45 lbs and up)	___	___	___ Twisting	___	___
___ Moderate (15-45 lbs)	___	___	___ Pushing	___	___
___ Light (up to 15 lbs)	___	___	___ Stooping	___	___
___ Reaching above shoulders	___	___	___ Kneeling	___	___
___ Straight pulling	___	___	___ Ability to read	___	___
___ Pulling hand over hand	___	___	___ Ability to type	___	___
___ Dual simultaneous grasping	___	___	___ Ability to write	___	___
___ Operating mechanical equipment			___ Hearing	___	___
Specify _____	___	___	___ Speaking	___	___
___ Operating office equipment			___ Climbing stairs	___	___
Specify _____	___	___	___ Simple grasp	___	___
___ Operating a motor vehicle	___	___	___ Repeated bending	___	___
___ Other: _____	___	___			

**Additional Recommendations/Restrictions:** (Health Care Provider: List if applicable)

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<b>Health Care Provider Signature:</b> _____	<b>Date:</b> _____
<b>Health Care Provider Printed Name:</b> _____	
<b>Approval of Hosting Department:</b> _____	<b>Date:</b> _____



Appendix C – Provider Examination Report

**SAMPLE PROVIDER EXAMINATION REPORT**

Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

History as Related by Patient:

\_\_\_\_\_  
\_\_\_\_\_

**Are your findings consistent with history and type of injury? Yes No Unsure**

**Is the injury work related? Yes No Unsure**

**Are there any current conditions that may affect recovery? Yes No Unsure**

**Please Explain:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Treatment Plan:** \_\_\_\_\_  
\_\_\_\_\_

**Patient Status:**  **Return to work with restrictions (see below)**

**May return to full duty work**

**Unable to return to work**

**If unable to return to work full duty, anticipated date of return to full duty:** \_\_\_\_\_

**Work Status:** *(Circle the level of limitation if applicable)*

Lifting:

Sedentary <10 lbs occasionally and up to 5 lbs frequently

Light 10-20 lbs occasionally and up to 10 lbs frequently

Medium 20-50 lbs occasionally and up to 20 lbs frequently

Heavy 50-100 lbs occasionally and up to 50 lbs frequently

Very Heavy >100 lbs occasionally and up to 100 lbs frequently

Bending	None	Occasional	Frequent	Constant
Squatting	None	Occasional	Frequent	Constant
Kneeling	None	Occasional	Frequent	Constant
Climbing	No fixed stairs	No Ladders		
Reach	Not with Right	Not with Left		
Grasping	Not with Right	Not with Left		
Pushing/Pulling	Not with Right	Not with Left		
Sit	None	Occasional	Frequent	Constant
Stand	None	Occasional	Frequent	Constant
Walk	None	Occasional	Frequent	Constant
Drive	None	Occasional	Frequent	Constant

Other: \_\_\_\_\_

\_\_\_\_\_

**Next Appointment Date and Time:** \_\_\_\_\_

**Health Care Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Appendix C – Sample letter to health care provider

**LETTER TO HEALTH CARE PROVIDER ABOUT RETURN-TO-WORK**

Dear \_\_\_\_\_:

(Name of Company) is committed to returning injured or ill employees to work within their capabilities. We believe that an employee who returns to work as soon as medically appropriate, and within his or her work restrictions, regains economic security, physical strength and flexibility, and has improved psychological well-being.

I am writing to ask for your opinion concerning Mr./Ms. \_\_\_\_\_'s ability to return to work at this time. Enclosed is an analysis of Mr./Ms. \_\_\_\_\_'s regular job (and/or proposed Transitional Employment Plan). Based on your review of the enclosed Return-to-Work Program (and/or proposed transitional employment plan) and your examination of Mr./Ms. \_\_\_\_\_, please choose one or more of the following:

I release the employee to the job as described in the Return-to-Work Program (or proposed Transitional Employment Plan) effective \_\_\_\_\_.

I release the employee to the activities as described under the following conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I cannot release the employee to any part of the duties described at this time.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

An appointment to review the employee's condition further is scheduled for \_\_\_\_\_.

Provider's Name \_\_\_\_\_ Date \_\_\_\_\_

Please feel free to provide any additional comments you have concerning Mr./Ms. \_\_\_\_\_'s ability to work.

Thank you for your assistance with this matter.

Sincerely,

Enclosure (Your Company name) Return-to-Work Program Details (and/or other attachments)

Appendix D – Sample Employee letter

(Organization Information)

Dear (employee Name)

Your Doctor has released you to return to work and we have a transitional duty position available for you that is designed to comply with your medical restrictions. Your transitional position will be (describe position or state unknown at this time). Your wages for this position will be (state amount or undecided or typical for this position or unchanged).

You are scheduled to return to work on (return Date) at (address / location). Your start time will be (time). Upon arrival please contact (supervisor) immediately. If you receive this letter after the start date listed above, please contact (claims administrator / supervisor immediately. Please remember failure to report to work could affect your workers compensation benefits.

If your transitional duty earnings are below you average weekly rate prior to your injury, you may be entitled to additional wage loss payments. Our workers compensation carrier will determine the exact amount you may be entitled to. We will then contact you to inform you of this benefit.

Please call (supervisor / claims administrator) if you have any questions about this offer. We are looking forward to having you back at work.

Sincerely,

(Senders information)