

Sample “Return-to-Work” Program

Continental Western Group

Continental Western Insurance • Tri-State Insurance • Union Insurance

11201 Douglas Ave., Des Moines, IA 50322

Loss Control Department

INTRODUCTION

We at Continental Western Group believe a “return-to-work” program is a viable mechanism that allows you the employer to encourage and allow employees to return to work as soon as possible after injury. The “return-to-work” program is specifically designed for employees who sustain job-related injuries and illnesses that are receiving workers’ compensation benefits. Many of the program elements are also usable for injuries sustained off the job which assist Short or Long Term Disability Programs.

The primary benefit of a “return-to-work” program is to facilitate the earliest possible return of injured workers to the workplace to perform meaningful, productive work within their physical capabilities. This program emphasizes employer/employee efforts to quickly return the employee to the productive workforce. It emphasizes the employee’s ability to return to the same or similar duties and tasks performed prior to the injury or to perform light duty tasks. The employees return to the job enhances productivity, reduces employee turnover, and reduces employee-related costs associated with workers’ compensation.

This guide provides procedures that will assist in implementing a viable “return-to-work” program. These procedures identify responsibilities and actions that should be taken by designated “return-to-work” coordinators, supervisors, and employees. This guide should not simply be adopted as your companies program without assuring the procedures can and will be followed. It is strongly recommended all policies and programs be reviewed by your companies legal representation. If you have additional questions about this material you can contact the Continental Western Group Loss Control or Workers’ Compensation Departments.

PRIMARY OBJECTIVES

Considerations in implementing a viable “return-to-work” program are:

- Provide the injured employee the necessary assistance to return to their normal work environment.

- Demonstrate the employer's concern for the employees well being and the desire for an early return to work. Timely communication with the injured employee is essential.
- Provide reasonable accommodation, whenever necessary and operationally feasible, to enable the injured employee to perform the essential functions of the job.
- Decrease the number of lost work days.
- Reduce the number of cases entering the workers' compensation litigation system.

BENEFITS OF THE "RETURN-TO-WORK" PROGRAM

The benefits of a viable "return-to-work" program are numerous.

Employer Benefits

- Reduced workers' compensation costs. Insurance premiums are directly related to the cost of claims; a consistent reduction in claims costs will result in a corresponding reduction in insurance premium.
- Reduced likelihood of malingering and/or fraudulent claims.
- Increase operational productivity. Most employees are in highly skilled positions; the return of the employee to the pre-injury or temporary duty position will increase productivity in the respective functional area.
- Goodwill is established between both the employee and, potentially, the public at large as the employer is viewed as one that cares for the employee.
- Eliminated or reduced cost of hiring and training new or substitute employees.
- Retention of trained and experienced employees.
- Co-workers are not required to assume the workload of the injured employee. Overworking employees may have a compound effect of increasing the injury rate in an operation.

Employee Benefits

- Improved self-esteem, morale and personal security from a productive lifestyle.
- Reduced financial hardship. Pre-injury wage rates are approximately thirty percent higher than temporary income benefits obtained through the workers' compensation system.
- Reduced stress over continued employment and boredom that typically results in the recuperation phase of an injury as the employee returns to the work environment.
- Maintain the pre-injury relationship with fellow employees.

- Maintain seniority and benefits while they recover.
- Keeps the injured worker mentally and physically conditioned to the regular work schedule.

Americans With Disabilities Act

The Americans with Disabilities Act (ADA), which became effective in 1992, increases employer accountability and responsibility to maintain employment opportunities for disabled workers. The law has reinforced the need for comprehensive disability management programs that can help control cost and retrain disabled workers with valuable skills. This is particularly important as the pool of qualified American workers shrinks.

ELEMENTS OF A “RETURN TO WORK PROGRAM”

The following elements are generally incorporated into an early “return-to-work” program. These elements are not all-inclusive and may be modified to meet your company requirements. The elements must be in written format.

Employer Actions:

- Involve senior management in active support of the goals. Be willing to make accommodations, such as allowing part-time work or temporary modified duty, which help aid recovery and early return to work.
- Involve all departments as participants in the program and they must support the program. Cross utilization of personnel may assist when determining availability of “light duty” work.
- Maintain strict confidentiality of medical information for the injured employee.
- Conduct a thorough analysis on all workplace injuries to determine the root cause and to assist the insurance company claims adjusters and medical personnel with claims management.
- Develop position descriptions and conduct thorough job assessments or job analysis to determine and document associated hazards and corrective actions. Additionally, the assessment should identify the specific functions of the job and its physical requirements. This is important in pre-employment evaluations as well.
- Identify those positions within the company that are suitable for “light duty” assignments. The physical requirements of the job should be documented to allow medical personnel to determine suitability. This documentation can be done on a job analysis form. Video clips can be helpful to show the doctor what the job actually entails. Do not forget tasks that managers do that can be delegated and be creative.

- Designate a “return-to-work” coordinator that is enthusiastic to oversee the program and assists supervisors and the injured employee in returning to work. The coordinator must be methodical in applying the “return-to-work” program and must maintain thorough documentation of all actions. Information such as the result of an injury may be confidential and should be handled accordingly.
- Include the “return-to-work” program and requirements for participation in the program in the employee orientation program. Additionally, the program should be reviewed with all employees annually. The coordinator should maintain documentation of this training.
- Start early intervention and implementation of the “RETURN-TO-WORK” program as this is instrumental to the program's success. As soon as feasible, the employee’s supervisor and the “RETURN-TO-WORK” coordinator should contact the injured employee to express concern over the employee’s well being, to express a desire for a speedy recovery and return to work, and to determine any special employee needs. It is important to remember that the employee may be experiencing both a physical and emotional trauma. Physical from the incurred injury and emotional from the unknowns of not working.
- Maintain close coordination/communication between the “RETURN-TO-WORK” Coordinator and the injured employee’s supervisor. The employer must ensure the information provided to the employee is accurate and does not conflict with other guidance.
- Designate a medical facility/doctor that will treat all job-related injuries and illnesses. Invite the medical provider to tour your facility to see job functions and work conducted. Explain the goal of your program and verify the medical provider is in agreement with your return to work philosophy. **Check with your state Workforce Development Department to determine if your state allows the employer to mandate the employee see the company designated medical facility/doctor for job-related injuries and illnesses.**
- Assure the employee who has returned to work is performing in accordance with medical guidance. The employer should reemphasize the specific requirements with the employee and identify all limitations.

Employee Actions:

- Assure employees understand the company policy on early return to work and acknowledge understanding of the policy by signature. A copy of the signed policy should be given to the employee; the original will be filed with the employer.
- Report all injuries to their supervisor right away.

- Communicate regularly the status of the injury and the expected date of return to work. The employee also has a responsibility to provide details of the injury and medical information to the assigned insurance company adjuster.
- Follow all medical provider directions and treatments so to not work beyond the medical limits.

Supervisor Actions:

- Always respond positively to the employee's first report of injury. Take time to handle the injury properly and authorize medical attention immediately.
- Complete the first report of injury form as well as investigate the accident or illness and record all pertinent information.
- Keep informed of the injured employee's progress and visit the employee or make contact to assure the employee that the "team" needs him/her.
- Make the returned employee feel welcome and glad to be back.
- Provide temporary modified duties that fit the approval of the physician and explain the duties clearly and emphasize the importance of this temporary job. Assure and point out any new safety precautions necessary.
- Monitor the employee to assure he/she works within the limitations set while assuring he/she and all employees around maintain a positive psychological state of mind about the employee and the job performed.

Definition of Return to Work Duty Assignments

Return to work duty assignments are separated into three distinct categories: Full Duty, Modified Duty, and Light Duty.

- **Full Duty:** Full duty is the performance of all duties and requirements for which the employee is employed. The release to full duty indicates the employee is capable of performing all essential and non-essential functions of the employee's hired position.
- **Modified Duty:** Modified duty is the performance of all essential functions of the pre-injury position with modifications to schedule or method of performance. The employee may perform only a portion of the assigned duties that are within the employee's current capabilities as outlined by the treating physician. Modified duty may include varying the hours of work, using mechanical means to assist performance, or using other employees to assist with job performance.

- **Light Duty:** Light duty is the performance of all essentials of a job or position other than that for which the person was hired. Light duty allows an employee to perform other duties and tasks that are permissible given medical limitations. These duties may or may not be at the permanent employment location. The light duty position offer should be for a specified time limit and at a specified rate. Light duty is a **temporary** assignment until the employee can resume the functions of the position for which employed. An example of light duty would be to use an auto technician to train other employees, to maintain service department documentation, etc. Assigned tasks must be consistent with the medical release for light duty. The employer should maintain a catalog of potential light duty assignments that are applicable to a specific job specialty (e.g. technician, porter, parts warehouse, etc.). The availability of an assignment is dependent on business activity.

Sample Forms:

The sample letters and forms, if used, should be modified to meet your specific requirements. You should add forms as necessary to meet your specific requirements. Maintenance of the forms will reside with the "RETURN-TO-WORK" coordinator.

- "Return-to-Work" Policy
- "Return-to-Work" Procedures
- Job Analysis Form - Sample
- "Return-to-Work" Coordination Worksheet
- Employee/Employer Communication Log
- "Return-to-Work" Correspondence
- Medical Light Duty Request Letter with Work Status Report
- Employer Offer of Light Duty
- Light Duty Work Agreement

Employment Law Disclaimer:

The purpose of this procedure is to establish guidelines for use by employers and employees in implementing a viable "return-to-work" program. This program is not intended to replace or supplement any existing federal or state requirements, but may work in concert with these programs (e.g. Federal Medical Leave Act, Americans for Disability Act). It is incumbent on management to insure compliance with all applicable rules and laws. ADA, FMLA, and other elements of employment law may apply following the injury of an employee. Communication with appropriate legal counsel may be appropriate.

“Return-to-Work” Policy

It is the policy of *company name* to provide a “return-to-work” program as the means to return employees to meaningful, productive employment following an on the job injury or illness. In order to provide the highest level of quality service to our customers, it is necessary for every employee of *company name* to be available for work, ready, and capable of performing the duties and responsibilities for which the employee was hired.

The “return-to-work” program provides opportunities for any employee of this company, who was injured in the course and scope of employment, to return to work at full duty. If the employee is not capable of returning to a full duty position, the “return-to-work” program provides opportunities when available for the employee to perform a temporary assignment in which the employee’s regular position is modified to accommodate the employee’s physical capacities, or to perform an alternate duty position.

This “return-to-work” program shall not be construed as recognition by this companies management, or its employees that any employee who participates in the program has a disability as defined by the Americans with Disabilities Act of 1990. If an employee sustains an injury or illness that results in a disability under the ADA, it is the employee’s responsibility to inform his or her supervisor or a person in a responsible management position when a disability under the ADA exists and that a reasonable accommodation is necessary to perform the essential functions of his or her job.

Specific procedures regarding the “return-to-work” program shall be provided to all employees. Management and employees of this company are expected to support and fully comply with this policy and the procedures implementing this policy.

Signed by Company President

“Return-to-Work” Procedures Injured Employee

Definitions: The following definitions apply to this procedure:

1. **Lost Time:** Time spent away from work at the direction of the treating doctor as a result of a compensable injury sustained in the course and scope of employment. The term does not include time worked in a temporary assignment.
2. **Full Duty:** Performance of all duties and tasks of the position for which the employee is employed. Full duty entails performing all essential and non-essential functions of the employee’s regular job.
3. **Temporary Assignment:** Performance of a temporary job assignment that is intended to return an injured employee to work at less than his or her full duties when a compensable injury or serious medical condition prevents the employee from working full duty. Two types of temporary assignments are modified duty and light duty.
4. **Modified Duty:** Performance of all of the essential functions, but only a portion of the nonessential functions and tasks of the regular job duties for which the employee is employed. Modified duty allows the employee to return to current employment in his or her regular job, and perform those duties and tasks that are within the capabilities of the employee, given the restrictions to duty imposed by the treating physician. Modified duty is a temporary arrangement until the injured employee can resume full duty.
5. **Light Duty:** Performance of the essential functions of a job or position other than the position for which the employee was hired. Light duty allows the employee to temporarily perform other duties and tasks that are within the limits imposed by the treating doctor. Light duty is a temporary arrangement until the injured employee can resume full activities of his/her regular position.

Prohibited Actions: This “return-to-work” policy and procedure shall not be applied to any situation or circumstance in a manner that discriminates on the basis of race, color, sex, national origin, religion, or disability.

It is a violation of the “return-to-work” policy, procedures and state or federal law for any employee, supervisor or manager of this company to:

- Discharge or in any other manner discriminate against an employee because the employee:
 - Files a workers’ compensation claim in good faith;
 - Hires a lawyer to represent the employee in a workers’ compensation claim;

- Limit, segregate, or classify a job applicant or employee in a way that adversely affects his or her employment opportunities or status on the basis of disability.
- Require a medical examination of an employee who is disabled as defined under the ADA unless the medical examination is job related and consistent with business necessity.
- Make inquiries as to whether an employee is an individual with a disability or as to the nature or severity of such disability.

Position Descriptions of All Positions: All supervisors and managers are responsible for identifying, documenting and maintaining the essential and non-essential functions in a position description for all positions for which they are responsible. The physical requirements of the position should be included in all position descriptions as either an essential or non-essential functions. All position descriptions shall be reviewed at least annually, and must be submitted for approval to the human resources manager.

Designated "Return-to-Work" Coordinator: A "return-to-work" coordinator shall be appointed in the Human Resources, Business Office, Office, etc. The "return-to-work" coordinator will be responsible for coordinating all activities associated with this program, unless specific duties are otherwise assigned to another person or position.

Education and Training: The "return-to-work" coordinator shall develop, maintain and provide an appropriate training module for inclusion in orientation training for new employees. The "return-to-work" coordinator shall also develop, maintain, and provide an appropriate refresher training module for presentation to employees on an as needed basis.

Employee Participation in the "Return-to-Work" Program: Employee participation in this program requires sustaining a compensable injury that results in lost time away from work. An employee who meets the criterion shall be encouraged to participate in the program. Whether or not you can mandate participation in this program may depend on your state regulations.

Notification of Injury or Illness: An employee who sustains an injury or illness either on or off the job will notify their immediate supervisor as soon as feasible. On the job injuries will be reported prior to departing the workplace. The immediate supervisor will notify the claims/"return-to-work" coordinator of the employees' injury and will perform an accident investigation to determine how and why the accident occurred. The results of the investigation will be documented in writing and will be maintained in the employee's folder.

Authorization for Lost Time: Healthcare providers must authorize an employees "off work" status for all compensable injuries. It is the employees responsibility to obtain the certification for "off work" status from the Healthcare Provider and to deliver the certification to his/her supervisor. A "Medical Certification Form" is included at attachment one. The employee's supervisor/"return-to-work" coordinator must ensure the employee takes a copy of the employee's job description to the

healthcare provider to allow a determination of whether the employee can perform the essential job functions.

Periodic Status Reports: If an employee is certified by a health care provider to be off work, the employee is required to submit periodic status reports to his/her supervisor to report the employee's status and intention to return to work. Such status reports are required at the time of each scheduled visit with the treating healthcare provider and are due immediately following the visit. A "Return-to-Work" Status Report" form is attached to this procedure for this purpose. The status report should be provided to the supervisor within 24 hours of the scheduled visit, or if a weekend or holiday is involved, before close of business on the next scheduled workday.

If an employee has returned to work in a temporary assignment, and follow-up health care provider appointments are necessary, the employee shall schedule the appointments to minimize time away from the job.

Communication with the Employee: At the time of first communication with the employee, the "return-to-work" coordinator shall provide information to the employee that contains the following, as appropriate:

- The companies "return-to-work" policy and procedures, and appropriate forms.
- Notification that the company provides workers' compensation insurance benefits to employees who sustain a work related injury or illness;

The "RETURN-TO-WORK" Coordinator is responsible for maintaining regular (weekly) communications with the employee. These should be communicated with the injured employees' supervisor. The purposes of these communications are to: encourage the employee during recuperation from the injury; communicate the value of the employee to the department, encourage return to work at the earliest possible date, and determine any special needs the employee may have that the company can help with.

Temporary Assignment Positions (Light Duty): If the healthcare provider certifies an employee for return to work at less than full duty, this company may provide a temporary position for the employee. The temporary position will be for a specified time and with specified scope of work. Supervisors are responsible for identifying light duty position requirements within their respective areas. The temporary assignments shall be coordinated with the "RETURN-TO-WORK" coordinator and the human resources manager. Light duty assignments shall be identified, assigned and managed on a case by case basis based upon operational requirements. The offer of temporary position shall be documented in a "bona fide offer of employment" letter to the employee (attachment two).

Bona Fide Letter of Employment Requirements: The bona fide offer of employment letter shall include the following information:

- The type of position offered (clerical, administrative, porter, service advisor, etc) and the specific duties;
- A statement that the company (policyholder) is aware of and will abide by any physical limitations under which the treating doctor has authorized the employee to return to work;
- The maximum physical requirements of the job;
- The location of the temporary employment;
- The expected duration of temporary employment;
- The consequences of not accepting a temporary assignment, in terms of duration and amount of temporary income benefits payable under the state worker compensation regulations. (Note: this information may be obtained from the insurance company adjusters). **The employee may accept or reject this bona fide offer of temporary employment.**
- The person to contact if the employee has questions regarding the temporary assignment or job modifications.

If the employee accepts the temporary duty assignment, then the employee shall perform the duties of the position for the term of the assignment or until released to full duty.

If the employee is unable to return to full duty by the end of the temporary assignment period, then the employee's continued employment shall be considered based upon the business necessity of having the employee's position filled and whether any reasonable accommodation is required by other state or federal directives.

JOB ANALYSIS

Employee: _____ Job Title: _____ DOT No.: _____
Employer: _____
Date of hire: _____ Date of job analysis: _____
Job analysis performed by: _____
Methodology Used: Observation/Interview Other – Explanation: _____

POSITION SUMMARY

1. Description of job: _____

2. Essential tasks: _____

3. Types of machines and equipment used: _____

4. Jobs can be modified: Temporarily YES NO Permanently YES NO
If yes, please specify how: _____

EDUCATIONAL & TRAINING REQUIREMENTS: _____

ENVIRONMENTAL CONDITIONS:

- Primarily: Indoor work Outdoor work
- Exposure to:
- | | | |
|--|---|--|
| <input type="checkbox"/> Confined Spaces | <input type="checkbox"/> High Elevations | <input type="checkbox"/> Slippery Surfaces |
| <input type="checkbox"/> Electrical Shock | <input type="checkbox"/> Humid | <input type="checkbox"/> Toxic Chemicals |
| <input type="checkbox"/> Explosives | <input type="checkbox"/> Moving Parts | <input type="checkbox"/> Uneven Surfaces |
| <input type="checkbox"/> Extreme Cold | <input type="checkbox"/> Noise | <input type="checkbox"/> Vibration |
| <input type="checkbox"/> Extreme Heat | <input type="checkbox"/> Poor Ventilation | <input type="checkbox"/> Weather |
| <input type="checkbox"/> Fumes/noxious odors/
dusts/mists/gases | <input type="checkbox"/> Radiant Energy | <input type="checkbox"/> Wet |
| | | <input type="checkbox"/> Other _____ |

Length of work day: _____ No. of Days/Week: _____
Breaks: _____ Duration of each: _____ Meal Break Duration: _____
Work Schedule: _____

PHYSICAL DEMANDS: **N/P** = Not Present.....0% of the time
 R = Rarely.....< 5% of the time
 O = Occasional <1/3 of work hours5-25% of the time
 F = Frequent 1/3 to 2/3 of work hours..25-75% of the time
 C = Constant > 2/3 of work hours75% or more of the time

	N/P	R	O	F	C	Description/Narrative
1. Balancing						
2. Carrying						
3. Climbing						
4. Crawling						
5. Crouching						
6. Driving						
7. Fingering						
8. Handling						
9. Hearing						
10. Kneeling						
11. Lifting						
12. Overhead Work						
13. Pulling						
14. Pushing						
15. Reaching						
16. Sitting						
17. Standing						
18. Stooping						
19. Talking						
20. Twisting						
21. Vision						
22. Walking						
23. Other						

* Please designate heaviest weight by frequency in appropriate column.

Employer: Date job is available: _____ Wage: _____ (per hour/week/year)

Comments: _____

Employer Signature _____ Date: _____

Physician I approve the attached job description. Yes No

If no, reasons for disapproval/recommended modifications: _____

Physician Signature _____ Date: _____

"Return-to-Work" Coordination Sheet

Employee (Claimant) Name: _____ SSN: _____

Employee Department: _____ Supervisor: _____

Description of Injury:

Description of Accident:

Date of Injury: _____ mm-dd-yy

Date Reported to Employer: _____ mm-dd-yy

Date of Initial Medical Appt: _____ mm-dd-yy

Date Reported to Insurance Carrier: _____ mm-dd-yy

Date Released Light Duty: _____ mm-dd-yy

Date Accepted Light Duty: _____ mm-dd-yy

Date Released Full Duty: _____ mm-dd-yy

Date Returned to Work: _____ mm-dd-yy

Remarks:

Sample Light Duty Request Letter (Employer to Medical Clinic)

Date

Medical Clinic

Attn: Doctor _____

Address

Address

RE: Request for Light Duty Assignment *(claimant name)*

Claim No: *(enter claim number)*

Dear Dr. _____:

It is our policy to provide our employees injured on the job with the opportunity to continue to work in a light duty status whenever operationally possible. The offer of employment to the employee will be in writing and will be for a specified time frame or until the employee is released to full duty.

The offer of employment and position of employment will be determined by the physical limitations placed on the employee because of his/her injuries. Please complete the attached "Work Status Report" and fax to *company fax number* or mail to the above address; the completed form will allow our company to determine the availability of light duty employment and to ensure the employee complies with medical restrictions.

Thank you for your time. Please contact me at *company phone number* should you have any questions on our light duty employment process.

Sincerely,

Human Resources Manager

cc: Insurance Company Adjuster

WORKERS' COMPENSATION WORK STATUS REPORT

Provide to injured employee at time of examination and fax or transmit to employer at time of initial examination or if work status has changed.

Carrier Claim # _____

PART I: GENERAL INFORMATION

Used for Transmission

1. Injured Employee's Name	6. Doctor's Name and Title	10. Date Being Sent	11. Number of Pages
2. Date of Injury	7. Federal Tax I.D. No.	12. Employer's Name	
3. Social Security Number	8. Professional License No.	13. Employer's Fax # or Email Address (if known)	
4. Date of This Visit	9. General Description of Injury	14. Insurance Carrier	
5. Date of Next Evaluation		15. Carrier's Fax # or Email Address (if known)	

PART II: WORK STATUS INFORMATION (FILL OUT ONE)

16. The injured employee's medical condition resulting from the compensable injury:

(a) has improved sufficiently to allow the employee **to return to work without restrictions** as of _____ (date).

(b) has improved sufficiently to allow the employee **to return to work with restrictions** as of _____ (date). The restrictions on the employee's work activities are noted in PART III of this report and are expected to last until at least _____ (date) when the employee is expected to be ready to return to work without restrictions.

(c) is such that the employee is/has been **unable to work** and restricted from all work as of _____ (date). This restriction is expected to last until at least _____ (date) at which time the employee is expected to be able to return to work with restrictions. The employee is expected to be able to return to work without restrictions by _____ (date). The following describes how the employee's workers' compensation injury precludes working in any capacity:

PART III: WORK RESTRICTIONS (COMPLETE IF BOX 16(b) IS CHECKED)

17. GENERAL WORK RESTRICTIONS	18. POSTURE/MOTION RESTRICTIONS		
<input type="checkbox"/> May only work ___ hrs/day <input type="checkbox"/> Sedentary only <input type="checkbox"/> Must wear splint/cast at work <input type="checkbox"/> Must use crutches at all times <input type="checkbox"/> Dressing changes necessary at work <input type="checkbox"/> No driving/operating heavy equipment <input type="checkbox"/> Can only drive automatic transmission <input type="checkbox"/> Must wear sunglasses <input type="checkbox"/> Must wear tennis shoes only <input type="checkbox"/> No skin contact with: _____ <input type="checkbox"/> No work / <input type="checkbox"/> ___ hours work <input type="checkbox"/> in extreme hot/cold environments <input type="checkbox"/> at heights or on scaffolding <input type="checkbox"/> No work in water <input type="checkbox"/> Stretching breaks every ___ hrs	<input type="checkbox"/> Employee has no posture restrictions <input type="checkbox"/> Employee has posture restrictions as follows: Hours per day 1-4 4-6 6-8 Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kneeling/Squatting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bending/Stooping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Twisting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pushing/Pulling <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Overhead reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Employee has no motion restrictions <input type="checkbox"/> Employee has motion restrictions as follows: Hours per day 1-4 4-6 6-8 Grasping/Squeezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Keyboarding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wrist flexion/extension <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Overhead reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Climbing stairs/ladders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Running <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
	19. LIFTING RESTRICTIONS	20. OTHER RESTRICTIONS	
	The employee is able to: <input type="checkbox"/> lift objects without restriction. <input type="checkbox"/> occasionally lift a maximum of ___ lbs; <input type="checkbox"/> frequently lift a maximum of ___ lbs; and <input type="checkbox"/> carry objects weighing up to ___ lbs.		

21. Signature of doctor	23. Type of Doctor: <input type="checkbox"/> Treating doctor <input type="checkbox"/> Consulting doctor <input type="checkbox"/> Designated doctor <input type="checkbox"/> Referral doctor <input type="checkbox"/> Other doctor <input type="checkbox"/> Carrier-selected RME <input type="checkbox"/> TWCC-selected RME
22. Date	

PART IV: OTHER INFORMATION

--

WORK STATUS REPORT INSTRUCTION

PART I: GENERAL INFORMATION	
1. Injured Employee's Name	Injured employee's complete name.
2. Date of Injury	Date the injury occurred or date an occupational disease was diagnosed.
3. Social Security Number	Injured employee's Social Security number.
4. Date of This Visit	Date of appointment during which work status evaluated for this report.
5. Date of Next Evaluation	Date injured employee is scheduled to return for a follow up examination to reevaluate work status.
6. Doctor's Name and Title	Name of doctor who examinationed employee and doctor's title.
7. Federal Tax Identification No.	Doctor's federal tax identification number.
8. Professional License No.	Doctor's professional license number.
9. General Description of Injury	A high-level generic description of the injury or condition (e.g. broken right arm, strained left knee, etc).
10. Date Being Sent	Date the report is being sent; this is to eliminate the need for a cover page.
11. Number of Pages	Number of pages being transmitted (by facsimile); this is to eliminate the need for a cover page.
12. Employer's Name	Business name of employer for whom the employee worked at the time of injury.
13. Employer's Fax # or Email	Fax # or Email address the report is being sent to (if being sent by Fax or email).
14. Insurance Carrier	Name of workers' compensation carrier at time of the employee's injury.
15. Carrier's Fax # or Email	Fax # or Email address the report is being sent to (if being sent by Fax or email).
PART II: WORK STATUS INFORMATION (FILL OUT ONE)	
16(a). Able to Work	Used to indicate the date the employee is/was released to return to work without restrictions.
16(b). Able to work with restrictions	Used to indicate the date the employee is/will be released to return to work with restrictions on work activity.
16(c). Unable to Work	Used to indicate that the employee is completely unable to work and is restricted from all work-related activity. A doctor who indicates that an employee is unable to return to work in any capacity must provide a detailed explanation of how the condition precludes all work.
<p>Notes on Boxes 16(b) and 16(c) - A doctor who indicates that an employee is unable to work or is only able to work under restrictions (boxes (b) and (c)) must include an estimated date of expiration for these restrictions. These estimates are required to enhance claims management and to provide the employer with information that can be used to plan work coverage and to plan for the employee's return to work (whether with or without restrictions). An estimated expiration is speculative in nature. The further out the date is projected, the less accurate it may be. Estimations are not binding and may be changed as needed based upon the condition and progress of the employee by filing a subsequent Work Status Report.</p>	
PART III: WORK RESTRICTIONS (COMPLETE IF BOX 16(b) IS CHECKED)	
17. General Work Restrictions	Allows the doctor to indicate common restrictions that may apply to the employee.
18. Posture/Motion Restrictions	Allows the doctor to indicate common restrictions on the employee's capacity to perform various common work postures and motions.
19. Lifting Restrictions	Allows the doctor to list any restrictions on the employee's lifting capacity that may exist.
20. Other Restrictions	Allows the doctor to list any other restrictions on the employee's ability to work that are not covered by the other portions of the report.
21. Signature of Doctor	Signature of the doctor who conducted the examination.
22. Date of This Report	Date report completed.
23. Doctor Type	<p>Treating: Doctor chosen by and primarily responsible for employee's injury-related health care. Consulting: Doctor who was selected by the treating doctor to provide an opinion on the employee's medical condition. Designated: Doctor selected by the Commission to evaluate whether the employee's medical condition has improved sufficiently to allow a return to work (only for SIBs claims). Referral: Doctor who was selected by the treating doctor to treat the employee's medical condition. Carrier-selected RME: Doctor selected by the insurance carrier. TWCC-selected RME: Doctor selected by TWCC. Other: Doctor who fits none of the above descriptions.</p>
Part IV: OTHER INFORMATION	
<p>This is an open box/area that allows the doctor to supplement the form with other information that he/she has found useful to provide to carriers and employers. Doctors need to be careful to not include information on the form that reveals confidential medical information the employer is not entitled. The employer is only entitled to information relating to the employee's work status.</p>	

Sample Company to Employee Letter (Follows release by medical facility)

Date

Mr./Ms. Claimant Name

Claimant Address

Claimant address

Dear Mr./Ms. Claimant Name:

Doctor of the Medical Clinic has given you a release to perform light/modified duty employment consistent with the physical limitations of your injury. Please report to your supervisor or "return-to-work" coordinator on day, date at time to begin employment under the "RETURN-TO-WORK" program. The light/modified duty program will consist of brief description of employment. A review of the light duty position will occur every thirty days to determine availability of continued employment under the program. Our goal is to assist you in the recuperative process until you can return to full duty employment.

Your failure to accept the light duty position may result in actions by this company consistent with your states Labor Code. You may direct any questions to Ms./Mr. "Return-to-Work" Coordinator or Human Resources Manager, at (xxx) xxx-xxxx.

Sincerely,

General Manager, Human Resources Manager, or "Return-to-Work" Coordinator

Cc: Doctor Name, Medical Clinic
Insurance Company Claims Adjuster

LIGHT DUTY WORK AGREEMENT

I, (emp. Name) _____, understand that I have been released by
(Dr.) _____ for light duty work effective (date) _____.

(Company) _____ extends to you an employment opportunity specifically designed to meet your special needs. The terms of this employment offer are as follows:

Work Schedule

_____ a.m. -- _____ p.m. _____ through _____

Compensation

_____ hour workweek with rate of pay set at \$ _____ per hour

Duties

Duties may include but are not limited to the following:

Duty Limitations

Employee Responsibilities

- *Report to work at assigned time.
- *Report to supervisor the date and time of all doctor and therapy appointments.
- *Notify supervisor as soon as possible in situations involving absence from work and tardiness.
- *Perform duties assigned by the supervisor in a satisfactory and timely manner.

I have read and understand the conditions of the LIGHT/MODIFIED DUTY WORK AGREEMENT as specified above.

I understand that I am required to report to work at (place) _____
directly to (name) _____
for job duty on (date) _____ at (time) _____

This agreement expires 30 days from date of execution; however, it can be renewed upon mutual agreement.

I accept the offer of Employment.

I ***do not*** accept the offer of Employment.

Employee _____
Supervisor _____
Date _____

Employee _____
Supervisor _____
Date _____