RETURN TO WORK PROGRAM

Research shows that the benefits to employers who provide accommodations to employees with disabilities to return to work far outweigh the costs. An organization's workforce is its most valuable asset. When an employee can't work due to an illness or injury, it impacts not only a company's productivity, but also its morale.

Our company is committed to providing opportunities for an employee who is injured on the job to return to work at full duty as soon as medically possible. If the injured employee is not physically capable of returning to full duty right away, this program offers an opportunity for the employee to perform his or her regular job with modifications or to perform alternate temporary work that is in line with his or her physical capabilities.

In fulfilling this company's commitment to provide a safe and healthy working environment, a Return to Work program has been established for employees who have sustained a workplace injury or illness. Its purpose is to return workers to employment at the earliest date following any injury or illness. The object is to speed recovery and reduce insurance costs.

Transitional work (temporary modified work assignments) will be made available in line with the worker's physical abilities, knowledge and skills based on a medical report furnished by employee's physician. (See Sample A – letter to treating doctor to release medical info, and Sample B – letter to be filled out and returned by treating Doctor re condition and needs of the injured party.)

The primary treating physician should clearly specify work capabilities, capacities and restrictions, both during an employee's recovery and after his condition has become permanent and stationery. This should be based on his medical condition and adjusted accordingly as his condition improves.

The primary physician's role should include notifying the Worker's Comp insurer after the first examination of an employee with a work related injury and communicating effectively with the injured employee and employer where necessary. Most transitional assignments should last no more than 90 days. Every return to work assignment should have a start and end date. Circumstances may require that these be modified from time to time, but they should never be open-ended.

_____is the individual who is responsible for obtaining relevant information from the employee's primary treating physician or healthcare professionals, his or her Worker's Compensation insurer and interacting with the other individual in this Company who is responsible for instituting specific accommodations for the injured party.

_____is the individual responsible for gathering complete and accurate information about the injured employee's work capacities and restrictions and assess possible accommodations needed. Communications will be respectful, open and done in a timely fashion. He or she will determine whether or not the accommodation is too costly for the company or would significantly disrupt business.

Lists of specific tasks outside regular jobs that could be done on a temporary basis will be compiled. These tasks can later be assigned to an injured employee while recovering and this type of work can aid in the recovery process as well as assist employees in a transition to a regular job.

If it is ascertained following the input of the treating physician as well as the individual responsible for making the necessary decision within the Company to offer transitional employment to the person involved, the Company will send him or her an Offer of Employment letter (see Sample C).

All employees should be familiar with this return to work process before an injury occurs. It is set up to make it possible for injured employees of this Company to return to work as soon as medically appropriate as it is mutually beneficial for all concerned.

SAMPLE A

AUTHORITY TO RELEASE MEDICAL INFORMATION

(*Employee Name)*
(Employee Address)
(Date of Birth)

I authorize (*name of treating doctor)* to release medical information to my employer, (*name and address of employer)* regarding my on-the-job injury that occurred on (*date of injury).*

This information is confidential and may not be used for any purpose other than relevance to the claimant's return to work.

This information may facilitate my return to medically appropriate productive work.

***(Print Employee Name)*_____**

***(Employee Signature)*_____**

***(Date)*_____**

SAMPLE B

To: (*Physician's Name*)
From: (*RTW Company Contact)*
Date:
Re: Transitional Work Assignment

_____(Company Name) has a Right to Work (RTW) program designed to help an employee reach full recovery following an occupational injury/illness. By completing this form, we may assist the employee in finding a temporary transitional assignment that matches his/her current work capability. Please fill out only what is applicable and return form to the employee or Fax to: _____. If you have any questions re this program, please contact _____at our Company.

1. **Positioning: Indicate which of the following should be avoided in each area….**
   ___prolonged standing ___bending ___twisting ___reaching overhead ___climbing
   ___walking ___prolonged sitting ___leaning forward ___crawling ___squatting
   Other_____

2. **Material Handling: Which of these situations should be avoided…..**
   __lifting over 10 lbs. ___lifting over 25 lbs. ___lifting over 50 lbs.
   __carrying objects ___lifting it off floor ___carrying objects
   ___lifting objects above shoulders ___pushing objects ___pulling objects
   Other_____

3. **Repetitive Motion: Which of the following should be avoided….**
   ___Keyboarding ___Other_____

4. **Time Limitation: For temporary transitional assignment…**
   ___number of hours per day ___number of days per week

   Estimate the length of temporary transitional assignment….
   ___1-5 days ___2 weeks ___3 weeks ___4 weeks ___5 weeks ___6 weeks
   ___greater than 6 weeks

   Date of next visit_____
   Date temporary transitional assignment can begin_____
   Date estimated to return to regular activities_____
   Program is not appropriate at this time because_____
   _____
   _____

   PHYSICIAN APPROVAL_____

   DATE_____

SAMPLE C

LETTER MAKING A BONA FIDE OFFER OF EMPLOYMENT

(Certified Mail – Return Receipt0
(Date)

(Employee Name)
(Employee address line 1)
(Employee address line 2)
(City, State, Zip)

Re: Bona Fide Offer of Employment

Dear (*Employee Name):*

After reviewing information provided by your Doctor, we are pleased to offer you the following temporary work assignment. We believe this assignment is within your capabilities as described by your Doctor. You will only be assigned tasks consistent with your physical abilities, skills and knowledge. If any training is required to do this assignment, it will be provided.

Job Title:
Location:
Duration of Assignment:
Wages:
Department:

This job offer will remain available for ten (10) business days from your receipt of this letter. If we do not hear from you within ten (10) business days, we will assume that you have refused this offer. Please note that refusal of an employment offer may impact your Temporary Income Benefit payments.

We look forward to your return. If you have any questions, please do not hesitate to contact me.

Sincerely,

(S*ignature)*
(Printed Name and Title)
(*Contact Information)*