**Return to Work Program**

This packet contains sample instructions and sample documents for implementing a Return to Work Program. Your company may wish to alter or re-arrange the information to meet your individual needs.

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**EMPLOYER PROCEDURE CHECKLIST**

**WHEN ESTABLISHING A RETURN TO WORK PROGRAM**

[ ]  Establish a written policy supporting Return To Work.

[ ]  Educate supervisors/managers about disability issues and their roles in company policy.

[ ]  Complete a description of job duties with the employees.

[ ]  Designate one individual (or the employee’s supervisor) to coordinate the injured employee’s return to work.

[ ]  Contact injured employees immediately following medical treatment.

[ ]  Facilitate cooperation and coordination among departments to return employees to work.

[ ]  Coordinate return to work activities with union representatives, if applicable.

[ ]  If job modifications are required, involve the employee in the process.

[ ]  Make follow-up contacts with injured employees at regular intervals.

[ ]  Maintain regular communication with the injured employee’s physician.

**RETURN TO WORK PROGRAM**

**SAMPLE POLICY**

**POLICY:**

***(Company Name***) recognizes the need to provide temporary modified work to employees who are unable to perform regular duties due to industrial illness or injury as soon as the treating physician deems it medically feasible.

**KEY POINTS:**

**SCOPE:**

This policy applies to all employees. Because of the limited amount of modified/alternate work positions available, employees are assigned on a “first come, first served” basis to appropriate positions as available.

**DEFINITION:**

An industrial “injury or illness” for purposes of this policy means an injury or disease arising out of or during the course of employment with ***(company name)***.

For purposes of this policy, an employee with a disability is an employee incapable of performing the regular duties of his/her assigned position as a result of industrial injury or illness, but who is able to perform some work and does not, therefore, have a “temporary total disability”.

**PURPOSE:**

To provide modified work for employees with job-related injuries/illnesses that restrict regular job performance so they can receive full compensation and benefits while recovering from the injury/illness.

To assist employees in the transition from disability to full recovery while continuing to be a productive part of the work group and leading a normalized life.

To provide management with a constructive program to reduce the cost of Workers’ Compensation.

To prevent deterioration of employee’s work skills, health, and attitude that may result from prolonged work absence.

To demonstrate the organizations’ commitment to the employee’s recovery. To minimize the loss of productivity.

**ELEMENTS:**

The modified/alternate work is implemented immediately to avoid lost time and to avoid loss of wages due to injury.

The temporary modified/alternate work is progressive so that there is evidence of recovery.

The temporary modified/alternate work assignment is not to be considered as part of the regular staffing pattern.

The permanent modified/alternate work assignment is considered as part of the regular staffing pattern.

**ELIGIBILITY QUALIFICATIONS:**

This program shall be limited to employees with a disability who are recovering from an industrial injury and who require temporary short-term, rather than permanent job reassignments.

The employee must have a medical clearance authorization slip from the attending physician specifying work restrictions and abilities.

**RESPONSIBILITIES:**

**PERSONNEL DEPARTMENT:**

Has the responsibility for coordinating the program. Personnel will work in cooperation with Department Managers, Supervisors, or Principals to achieve maximum acceptance of the program. Personnel has the responsibility to determine the employee’s eligibility for the program, for placement in modified/alternate work, for record keeping, and overseeing the modified work program and full return to work, where possible.

**MANAGERS/SUPERVISORS/PRINCIPALS:**

Will develop with Personnel and maintain an inventory of potential assignments to be kept on file, both in their department and the Personnel department to facilitate placement of the injured worker, and upon request from Personnel, develop possible short-term modified/alternate assignments for the injured employee.

Will review the employee’s restrictions for work with the employee prior to the beginning of work. Both the employee and department manager shall sign an agreement acknowledging any restrictions and forward the original to Personnel.

Will monitor the injured employee’s work area and ensure compliance with the physician’s work restrictions.

Will keep track of hours worked and evaluate work performance of temporary modified/alternate work employees and ensure that the injured employee’s salary is charged to the RTW Department code.

**PROCEDURES:**

**IMPLEMENTATION:**

1. Personnel will identify departments with modified/alternate work positions available.
2. Personnel shall advise each injured employee and his/her physician of the program and provide the physician with the necessary forms for completion by the physician.
3. The employee shall notify Personnel of his/her release to return to work in the RTW program.
4. If a doctor’s release is received directly by Personnel, a phone call will be made to the employee letting the employee know of the RTW program, and this will be followed by an explanation in writing.
5. A determination will be made by Personnel as to whether or not a modified/alternate work assignment can be provided which will be consistent with the treating physician’s work release.
6. All work provided will be consistent with and not exceed the limitations given by the treating physician.
7. While an employee is in the RTW program, he/she must report to work in usual appropriate attire, unless approved by Personnel.
8. When feasible, every effort will be made to accommodate the needs of the employee by modifying his/her present work setting, however, work availability may make it necessary to transfer employees from one division or department to another.

**TEMPORARY MODIFIED/ALTERNATE WORK:**

The employee assigned to temporary modified/alternate work will be paid the regular pre-injury hourly rate which will be charged to the Workers’ Compensation budget. The time card is sent to the employee in his/her regular or newly assigned department at the beginning of each pay period. He/she will code hours worked to the RTW program code. The supervisor of the area where the employee is performing temporary modified/alternate work duties will initial the hours worked in his or her area. At the end of the pay period, the time card will be taken by the employee to payroll for processing.

* Supervisors of the temporary modified/alternate work areas will be expected to keep track of hours worked and evaluate work performance.
* It is the option of ***(Company Name)*** to change regular days off and work hours while and employee is in the RTW program.
* Hours of work will be designated by the temporary modified/alternate work program supervisor. No overtime will be paid while in the temporary modified/alternate work program.
* RTW program participants are encouraged to schedule physical therapy and doctor’s appointments around their work schedules to avoid loss of earning power. If this cannot be arranged, appointments should be scheduled at the beginning or end of the work day. All appointments requiring time away from work must have written verification of time in and out of the facility to present to Personnel.
* All employees will abide by the work/safety rules at the location of their modified/alternate work assignment.
* If an employee is unable to report for work for personal reasons, he/she must call and report to the supervisor and to Personnel.
* If an employee’s health status changes, it must be reported immediately to the supervisor and to Personnel.
* When an injured/ill employee is released to participate in the RTW program he/she does not have the option to substitute paid sick leave because he/she does not personally feel ready to perform temporary modified/alternate work.
* Employees with restrictions that would permanently prevent them from returning to their former or available full time positions will remain off work and will not be provided temporary modified/alternate work assignments. Permanent modified/alternate assignments will be considered.
* While in the temporary modified/alternate work program, employees will stay no longer than four weeks on any one task, unless approved by Personnel.
* While in the temporary modified/alternate work program, employees who have experienced an on-the-job injury will be evaluated at thirty days or when medically stationary, whichever occurs first.
* A status review involving management and the employee will be performed at two-week intervals or more often if deemed necessary.
* After thirty days in the temporary modified/alternate work program, the eligibility for modified work will be reviewed. If the employee is not expected to return to regular work within thirty days, he/she may be removed from modified work until an expected return to work date has been determined. After consultation with the manager, physician, and Personnel, Personnel may extend the time period for the temporary modified/alternate work program on a week to week basis for a period of sixty days.
* As long as work can be provided, there is no right of refusal, without jeopardizing benefits and entitlements.
* Hours worked under modified/alternate work assignments will be considered “productive hours” in the computation and eligibility for getting benefit pay and accruals.
* Time worked under temporary modified/alternate work assignment will be considered as any other time worked in determining service credit.
* Time spent on personal sick or other absence will be treated in the same manner as when on regular duty.
* When employees are released to their regular job duties, the information will be provided to Personnel.
* A schedule of employees involved in the modified/alternate work program will be maintained by Personnel.
* Personnel will maintain ongoing contact with employees in the temporary modified/alternate work program to assess the process and progress of the employee.

*NAME OF COMPANY*

*ADDRESS*

*CITY, STATE, ZIP CODE*

**RETURN TO WORK**

**GUIDELINES**

In order to minimize serious disability due to on- the- job injuries and to reduce the effects to our injured employees, we have developed guidelines to deal with time loss claims in which the employee can be offered modified work, temporarily. Modified jobs will be identified after obtaining and examining the injured employee’s physical limitations or restrictions. “Modified” might be the employee’s regular job, modified by removing heavier tasks and reassigning these to other employees; a different regular job currently existing at the workplace; or a job which is specifically designed around the employee’s restrictions.

 A modified job offer will be made only when the work is available and of benefit to the company. The modified job, if offered, will end with the date the employee receives a regular release, and may be ended at any time if there is no longer a need for the modified work. Each case will be assessed individually based on need. Modified work may not be implemented in every time loss claim. Wages will not necessarily be the same as that of the regular job.

On-the-job injuries and occupational diseases will be handled by a team consisting of the injured employee, his or her supervisor, the office manager or designee, the company owners, the insurance company, and the injured employee’s physician. The team approach is the most effective method for achieving a return to productive work at the earliest opportunity. Responsibilities of the injured employee, the supervisor, and the office manager are outlined in the following pages.

*NAME OF COMPANY*

3

 3

*ADDRESS*

*CITY, STATE, ZIP CODE*

**GUIAS PARA QUE REGRESE AL TRABAJO**

Para minimizar la incapacidad grave debido a los accidentes de trabajo y para reducir las consecuencias a nuestros trabajadores lastimados, hemos desarrollado guias para tratar con las demandas de tiempo perdido donde podemos ofrecer trabajo modificado por un tiempo limitado. Trabajos modificados seran identificados despues de obtener y examinar las limitaciones fisicas del trabajador lastimado. “Modificado” puede ser el trabajo regular del empleado, modificandole o quitandole algunas tareas pesadas y repartirlo entre otros empleados; un trabajo diferene que regularmente exista en el lugar de empleo o un trabajo disenado al rededor de las limitaciones del empleado.

 Una oferta de trabajo modificado se hara cuando el trabajo es provechoso y de beneficio a la compania. El trabajo modificado, si lo es ofrecido , se terminara en la fecha que el doctor le de de alta a su trabajo regular o puede terminarse en cualquier momento, cuando ya no se necesite el trabajo modificado. Cada caso sera revisado individualmente segun la necesidad. Trabajo modificado no podra ser ofrecido en todos los casos donde hay perdida de dias/horas de trabajo. El pago talvez no sea precisamente igual al de trabajo regular.

Los accidentes y enfermedades de trabajo seran tratados por un equipo compuesto de el trabajador lastimado, el superintendente, director de la oficina, los duenos de la compania, la compania de seguro y el medico del trabajador. El esfuerzo del equipo sera el metodo mas eficiente para regresar al trabajador lastimado a su trabajo regular lo mas pronto posible. Las obligaciones del trabajador lastimado, Superintendente/Supervisor y Director de oficina estan sumados en las paginas siguientes.

**Return To Work Guidelines**

**3-S**

**for Office Manager / Personnel**

Check when done

When an injury occurs, office manager determines if medical treatment was provided.

If no treatment was provided, request Supervisor’s Report of Accident

If treatment was provided, office manager requests Supervisor’s Report of Accident and Employer’s Report of Injury (Complete form \_\_\_ as needed and forward immediately to \_\_\_\_\_\_\_\_\_\_\_\_ Insurance.

Office manager follows up on the Claim for Workers’ Compensation Benefits and on the Report of Physician form.

The Office manager or the supervisor follows with the physician after the first exam for status. The contact person (office manager/supervisor) will communicate the feedback to the other (office manager/supervisor).

If employee is off work, the office manager/supervisor should follow with the employee weekly to express care and concern.

The Office manager/supervisor follows with the physician after each next appointment for status; provides feedback to the other. If worker is released to modified duty, discuss modified duty possibilities together and with the owner as soon as possible.

If modified job is available, prepare written Job Offer, send Modified Duty Approval cover letter and Modified/Alternate Job Description Worksheet (if appropriate) to the physician for approval.

Contact your insurance company’s Return To Work Consultant if any assistance is needed.

If physician approves modified job, advise supervisor and have the supervisor contact employee to make job offer.

Notify the Claims Adjuster, by phone or by fax, of the Return to Modified Work date. Also, forward copies of the restrictions, job description, physician’s approval, and job offer to Claims Adjuster for file documentation.

Office manager monitors modified job by periodically checking with supervisor. If restrictions change, discuss with supervisor any need to revise duties assigned.

Monitor progress until employee is released to regular duty assignment. Relay information to the Claims Adjuster on status and Return to Work dates.

**Return To Work Guidelines**

4

**for Supervisors**

Check when done

As soon as aware of injury, coordinate first aid/medical treatment as appropriate, complete Supervisors Report of Accident, if appropriate.

 If medical treatment is required, (or if worker insists on filing a claim), complete Employers’ Report of Injury.

 Give employee Claim for Workers’ Compensation Benefits and Your Guide To Workers’ Compensation pamphlet.

 If possible, supervisor should accompany worker to the doctor. If employee has not predesignated a choice of physician and is not clearly in need of emergency room treatment, employee will be taken to the physician predesignated by the company.

 Ensure the Report of Physician form and Job Description of employee’s regular job is submitted to the doctor at the first medical visit. Require the employee (or if unable, employee’s agent if possible), to return the form the same day.

 Notify personnel/office manager of the injury and turn in copies of the applicable reports that day.

The supervisor or the office manager should follow with the physician after the first exam for status. The contact person (supervisor/office manager) will communicate the feedback to the other (supervisor/office manager).

 If employee is off work, supervisor/office manager follows with employee weekly

 to express care and concern.

 Supervisor/office manager follows with physician after each next appointment for status; provides feedback to other. If worker is released to modified duty, discuss modified duty possibilities together.

 If appropriate modified duty is available, telephone employee to advise and send written notice of job offer by certified mail-RRR, as well as by regular mail.

Upon employee’s return to work, ensure office receives physician’s release to return to work form. Complete Job Offer Acceptance form and Modified Duty Assignment form.

Ensure employee on modified duty does not exceed restrictions assigned.

Supervisor/office manager relays any changes in restrictions to the other and together discuss possible need for revising the modified job.

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*Company Name*

*Address*

*City, State, Zip Code*

**Return To Work Guidelines**

**for Employee**

Check when done

Report all injuries to your supervisor **immediately**. If medical treatment is needed and you have not predesignated a choice of physician, you should go to the physician predesignated by the company.

Complete the Claim for Workers’ Compensation Benefits and return it to your supervisor or personnel department as soon as possible.

Take the Physician’s Report form and Job Description Worksheet with you to your first medical appointment. Be sure the doctor returns the completed Physician’s Report form to you before leaving the appointment. Return the Physician’s Report form to your supervisor or personnel office the same day.

If you are not released for regular duty but are released for modified work, advise your supervisor and ask if modified duty appropriate to your restrictions is available.

If / when an appropriate modified job is developed, whether it is modification of your regular job or another job, you must report for work at the time designated by the company.

If you return to a modified job during the period of medical recovery, you must be certain not to exceed the restrictions assigned by your doctor. If your restrictions change you must notify your supervisor immediately and provide a copy of the doctor’s new release slip.

If you are taken off work completely or if no modified work is available, you must report your medical status to the office manager at least once a week.

Be sure the office always has your current mailing address and phone number.

*Company Name*

 6

*Address*

*City, State, Zip Code*

**Guias Para Que Regrese al Trabajo**

**para el Empleado**

marcar cuando

 se completa

Reporte todos los accidentes de trabajo a su Superintendente **inmediatamente**. Si tratamiento medico es necesario y no ha escogido su medico adelantado, usted debe de ir al medico designado por la compania.

Complete la forma de Beneficios de Compensacion para el Obrero y entregaselo a su Superintendente o Departamento de Personal lo mas pronto posible.

Lleve la forma Reporte del Medico y la forma Descripcion de su Trabajo con usted a su primera cita medica. Asegurese que el medico le entrega la forma Reporte de Medico completado antes que se termine su cita. Entrege la forma Reporte de Medico a su Superintendente o Oficina de Personal ese mismo dia.

Si no le dan de alto para su tarea regular pero le dan de alto para trabajo modificado, aconseja a su Superintendente y pregunte si la tarea modificado segun sus restricciones es disponible.

Si y cuando un trabajo modificado apropiado se desarrolle, sea modificacion de su trabajo regular o otro trabajo, usted debe de ir al trabajo a la hora designado por su compania.

Si usted regresa a un trabajo modificado mientras lo estan tratando medicamente usted debe de cuidarse de no pasar los limites de las restricciones imponidos por su medico. Si su restricciones cambian usted debe de notificar a su Superintendente inmediatamente y proveer una copia del papel del medico que le da de alta.

Si lo quitan del trabajo completamente o trabajo modificado no es disponible, usted debe de reportar su condicion medica al director de la oficina por lo menos una vez a la semana.

Tenga por seguro que la oficina tenge su domicilio corriente y numero de telefono.

 6-S

**JOB DESCRIPTION DEFINITIONS**

The following definitions coordinate with some of the terms you will find on the Job Description Worksheet, the Modified Job Description Worksheet and the Report of Physician. These definitions will be useful in helping you complete the forms. Any medical restrictions should be more uniform with and easier to apply to the job duties.

SITTING : Remaining in a seated position.

STANDING : Remaining on one’s feet in an upright position at a work station

 without moving about.

WALKING : Moving about on foot.

LIFTING : Raising or lowering an object from one level to another (includes

 inward pulling).

CARRYING : Transporting an object, usually holding it in the hands or arms, or

 on the shoulder.

PUSHING : Exerting force upon an object so . that the object moves away

 from the force (includes slapping, striking, kicking, and treadle

 actions).

PULLING : Exerting force upon an object so that the object moves away

 from the force (includes jerking).

BENDING : Forward motion of the upper body from the waist.

KNEELING : Bending the legs at the knees to come to rest on the knee or

 knees.

SQUATTING : Bending the body downward to rest the buttocks on the heels of

 the feet or back of the legs.

CLIMBING : Ascending or descending ladders, stairs, scaffolding, ramps,

 poles, ropes and the like, using the feet and legs and/or hands

 and arms.

CRAWLING : To move the body along on hands or knees (or on hands,

 stomach and knees).

REACHING : To extend arms forward to work or to retrieve.

 7

POWER GRASPING : Use of fingers, palm and wrist to hold and/or manipulate

 objects (hammers, saws, etc.) the instrument cannot be easily

 pulled from the grasp.

FINE MANIPULATION : Picking, pinching, or otherwise working with the fingers primarily

 (rather than with the whole hand or arm as in handling).

OPERATING : Entails the use of one or both arms or hands and/or one or

 both feet or legs to move controls on machinery or equipment

 Controls include but are not limited to buttons, knobs, pedals,

 levers, and cranks.

ENVIRONMENTAL

FACTORS : Whether the job is indoors or outdoors, extremes in temperature

 or humidity, exposure to dust, gas or fumes, exposure to noise

 or vibration.

FREQUENCY : Intermittently = 1% to 5% of the day;

 5 min. to 25 min. in a day;

 up to 1/20th of the time;

 approximately 1/2 hr. to 2 hrs. in a week.

 Occasionally = 6% to 37% of the day;

 30 min. to 3 hrs. in a day;

 1/20th to 1/4th of the time;

 approximately 2 1/2 hrs. to 15 hrs. in a week.

 Frequently = 38% to 75% of the day;

 3 hrs. to 6 hrs. in a day;

 1/4th to 3/4th of the time;

 approximately 15 hrs. to 30 hrs. in a week.

 Constantly = 76% to 100% of the day;

 6 hrs. to 8 hrs. in a day;

 3/4th to all of the time;

 approximately 30 hrs. to 40 hrs. in a week.

**Job Description Worksheet**

Employee : Job Title : DOT Code (if known) : \_

Work Hours : Work Days : Date :

Employer : Address : Phone # :

**Job Summary** : (Brief general description of job)

Physical Demands

*Intermittent =* ***1-5 %*** *Occasional =* ***6-37 %*** *Frequently =* ***38-75 %*** *Continuous =* ***76-100 %***

**Sitting** - Percentage of time or hours per day

**Standing** (stationary) - Percent of time or hours per day, surface type, foot control

**Walking** - Percent of time or hours per day, intermittent/continuous

**Lifting** - Weight, type of object, frequency

**Carrying** - Weight, type of object, frequency, distance

**Pushing** - Weight, type of object, times per hour, distance

**Pulling** - Weight, type of object, times per hour, distance

**Bending** - Frequency, duration

**Kneeling** - Frequency, duration

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Physical Demands- cont.

**Squatting** - Frequency, duration

**Climbing** - Frequency, height, slope, number of steps, on what

**Crawling** - Frequency, distance, surface

**Reaching** - Right, left, both, frequency, overhead, shoulder, chest, waist, below waist level

**Grasping** - Right, left, both, frequency, power/simple

**Manipulation** - Right, left, both, frequency, fine/gross

**Operating** - Machines, tools, equipment, vehicles

**Environmental Factors** - Is the job indoors or outdoors, extremes of cold, heat, humidity, noise, vibration, dust

**Comments** -

Employer Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_/\_\_\_/\_\_\_

Employee Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_/\_\_\_/\_\_\_

***Name of Company***

***Address***

***City, State, Zip Code***

Doctor’s Name

Address

City, State, Zip Code

Dear Doctor

We at (***company name***) are committed to returning our employees recovering from industrial injury or occupational illness to modified jobs whenever possible. Identification of availability of appropriate modified duty will be made on a case by case basis after obtaining and evaluating the employee’s medical or physical limitations or restrictions.

As the treating physician, your evaluation and cooperation is essential in determining when an employee considered temporarily disabled from his or her regular occupation, is able to return to productive modified work duties. The modified job, if offered, will end on the date the employee receives a release to his or her regular duties, and may be ended at any time there is no longer a need for the modified work.

The forms you will be asked to review and complete are enclosed for your review.

Thank you in advance for your cooperation in the effort to return our employees to productive work.

Sincerely

Name

Title

Phone Number

Enc.

 9a

**JOB DESCRIPTION DEFINITIONS**

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 9c

Physical Demands- cont.

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**Climbing** - Frequency, height, slope, number of steps, on what

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**Grasping** - Right, left, both, frequency, power/simple

**Manipulation** - Right, left, both, frequency, fine/gross

**Operating** - Machines, tools, equipment, vehicles

**Environmental Factors** - Is the job indoors or outdoors, extremes of cold, heat, humidity, noise, vibration, dust

**Comments** -

Employer Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_/\_\_\_/\_\_\_

Employee Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_/\_\_\_/\_\_\_

Instructions to Employee: Take this form to the doctor to complete the bottom portion. This form must be returned to your supervisor at *Company Name*.

Name of employee:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical Treatment

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ facility referred to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Supervisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**REPORT OF PHYSICIAN**

Please review the description of job duties and complete the below information for the employee to return to his/her supervisor immediately following examination.

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

[ ] **MAY NOW RETURN TO REGULAR WORK DUTIES WITHOUT RESTRICTION**

[ ]  **MAY RETURN TO WORK** *2 4 6 8* ( ) HOURS PER SHIFT

[ ] **MAY RETURN TO WORK WITH RESTRICTIONS**

***CAN NOT:***

 { } **sit**  anytime **/** prolonged more than \_\_\_\_\_minutes **/** hours of every \_\_\_\_\_hour**/**s

 { } **walk/stand** anytime **/** frequently **/** repetitively **/** # of times \_\_\_\_\_per hour / day

 { } **lift/carry** more than *10 20 30* \_\_\_\_*lbs*. anytime / frequently / repetitively

 { } **push/pull** more than  *10 20 30* \_\_\_\_*lbs*. anytime / frequently / repetitively

 { } **bend/stoop** anytime **/** frequently **/** repetitively **/** # of times \_\_\_\_\_per hour / day

 { } **kneel/squat** anytime **/** frequently **/** repetitively **/** # of times \_\_\_\_\_per hour / day

 { } **climb** anytime **/** prolonged more than \_\_\_\_\_minutes **/** hours of every \_\_\_\_\_hour**/**s

 { } **crawl** anytime **/** frequently **/** prolonged

 { } **reach** anytime **/** prolonged at **/** at or above **/** below shoulder **/** eye **/** head

 { } **grasp** power **/** simple right **/** left **/** both hands anytime **/** repetitively

 { } **manipulation** fine **/** gross right **/** left **/** both hands anytime **/** repetitively

 { } **operate** vehicles **/** moving equipment **/** other dangerous machinery

 { } **other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

[ ] **MAY NOT RETURN TO ANY WORK UNTIL**: *date* **\_\_\_/\_\_\_/\_\_\_**

[ ] **APPOINTMENT**: *date* **\_\_\_/\_\_\_/\_\_\_**

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

 Physician’s Name Physician’s Signature Date

 (Please Print)

9d

**COMPANY NAME**

**ADDRESS**

**CITY, STATE, ZIP CODE**

Date Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Claim # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Injury Date : \_\_\_\_ /\_\_\_\_ /\_\_\_\_

DOCTOR’S NAME

ADDRESS

CITY, STATE, ZIP CODE

Dear Doctor

We have received your release for ( *employee name* ) to return to restricted duty and we have located a temporary position.

**Of the usual job duties outlined in the job description, we plan to modify the duties as follows :**

 ***Limit*** : *1*. ( *list activity restricted* ), ( *over ( # ) pounds, to ( # ) hours / day, other please specify* ).

 *2*. ( *list activity restricted* ), ( *over ( # ) pounds, to ( # ) hours / day, other please specify* ).

 *3*. ( *list activity restricted* ), ( *over ( # ) pounds, to ( # ) hours / day, other please specify* ).

***Eliminate*** : ( *list activity* / *activities* ).

**The following duties will be added to replace the eliminated duties** :

 *1.* ( *list duty and brief description* ).

 *2.* ( *list duty and brief description* ).

**Working hours will be rearranged as follows :**

***Limit*** : ( *hours to* ***:*** *( # ) per day* ***;*** *days per week to* ***:*** *( # ) consecutive days, or ( S M T W T F S )* )*.*

**PHYSICIAN’S RELEASE**

THIS JOB **IS** APPROVED [ ] RELEASE DATE : \_\_\_\_/ \_\_\_\_/\_\_\_\_

THIS JOB **IS NOT** APPROVED [ ] PLEASE EXPLAIN : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

PHYSICIAN’S NAME : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN’S SIGNATURE : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE : \_\_\_\_/ \_\_\_\_/ \_\_\_\_

**Modified / Alternate - Job Description Worksheet**

 9e

Employee : Claim # : Date of Injury:

Modified Job Title : DOT Code (if known) :

Work Hours : Work Days : Date :

Employer : Address : Phone # :

**Job Summary** : (Brief general description of job)

Physical Demands

*Intermittent =* ***1-5 %*** *Occasional =* ***6-37 %*** *Frequently =* ***38-75 %*** *Continuous =* ***76-100 %***

**Sitting** - Percentage of time or hours per day

**Standing** (stationary) - Percent of time or hours per day, surface type, foot control

**Walking** - Percent of time or hours per day, intermittent/continuous

**Lifting** - Weight, type of object, frequency

**Carrying** - Weight, type of object, frequency, distance

**Pushing** - Weight, type of object, times per hour, distance

**Pulling** - Weight, type of object, times per hour, distance

**Bending** - Frequency, duration

**Kneeling** - Frequency, duration

 9f

Physical Demands- cont.

**Squatting** - Frequency, duration

**Climbing** - Frequency, height, slope, number of steps, on what

**Crawling** - Frequency, distance, surface

**Reaching** - Right, left, both, frequency, overhead, shoulder, chest, waist, below waist level

**Grasping** - Right, left, both, frequency, power/simple

**Manipulation** - Right, left, both, frequency, fine/gross

**Operating** - Machines, tools, equipment, vehicles

**Environmental Factors** - Is the job indoors or outdoors, extremes of cold, heat, humidity, noise, vibration, dust

**Comments** -

PHYSICIAN’S RELEASE

This job **is** approved [ ] Release Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

This job **is not** approved [ ]

Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_/\_\_\_/\_\_\_

***WHEN AN INJURY OCCURS***

**CHECKLIST**

**Check when done**

Complete **:** Supervisor’s Report of Accident.

Complete **:** Employer’s Report of Injury **;** send to Insurance Company.

Provide injured employee with **:**

* Claim for Workers’ Compensation Benefits
* **“**Your Guide to Workers’ Compensation**”** pamphlet .
* Job Description Worksheet of regular job.
* Report of Physician.
* Return to Work Guidelines for Employee.

Take or send injured employee to doctor or hospital.

Have employee or supervisor bring back Report of Physician.

If released to modified duty, identify modified / alternate work if available.

Request physician’s approval of modified job.

Prepare formal job offer to employee.

Notify the claims adjuster, of RTW-mod. date, phone or fax.

Send adjuster copies of restrictions, job description, doctor’s approval and job offer.

Monitor the modified duty and revise as restrictions change until released to regular duty.

10

**Supervisor’s Report of Accident**

11

**Claim for Workers’ Compensation Benefits**

13a

**Pamphlet – Your Guide to Workers’ Compensation**

13b

*NAME OF COMPANY*

*ADDRESS*

*CITY, STATE, ZIP CODE*

*Date*

 *date of injury : \_\_\_/\_\_\_/\_\_\_*

*Employee’s Name*

*Address*

*City, State, Zip Code*

Dear Employee

We at ( *company name )* are committed to returning our employees recovering from industrial injury or occupational illness to modified jobs whenever possible. Identification of availability of appropriate modified duty will be made on a case by case basis after obtaining and evaluating the medical or physical limitations or restrictions given by your treating physician. The modified job, if offered, will be evaluated periodically and will end when the physician has provided a release to return to regular job duties. The modified job may end at any time there is no longer a need for modified work.

Your treating physician has been asked to cooperate in the determination of when you may be able to return to work on either a regular or modified duty basis. Enclosed is the description of your regular job duties and a Report of Physician form. Please take these to your doctor on your next appointment date and ask that the Report of Physician form be completed and given back to you before you leave your appointment.

Please return the completed form within 24 hours to ( *me, your supervisor, Mr./Ms. ... , the personnel department, etc.* ). Please call ( *name* ) at ( *phone #* ), if you have **any** questions.

Thank you in advance for your cooperation and we look forward to your speedy recovery and return to work.

Sincerely

( *NAME* )

TITLE

Enc.

*NAME OF COMPANY*

 13c

13c

*ADDRESS*

CITY, STATE, ZIP CODE

 */ /\_\_*

fecha de lastimadura : \_\_\_/\_\_\_/\_\_\_

Estimado ,

Nosotros en estamos cometidos a regresar nuestros empleados recuperandose de la lastimadura industrial o enfermedad professional a trabajos modificados cuando posible. Para identificar el provecho de tarea modificado sera hecho en un base caso por caso despues de recibir y revisar el reporte de su medico dando sus limitaciones fisicas. El trabajo modificado, si es ofrecido, sera revisado periodicamente y se terminara cuando su medico le haiga dado de alta para regresar a su trabajo regular. El trabajo modificado puede terminarse a cualquier momento tambien si ya no se necesita el trabajo modificado.

Le hemos pedido a su medico su cooperacion en concluyendo cuando podria regresar al trabajo regular o modificado. Incluso esta la descripcion de la tarea regular de su trabajo y la forma Reporte del Medico. Por favor lleve estas formas a su medico cuando tenga su proximo cita y pida que completen la forma Reporte del Medico y que se lo regresen antes que se termine su cita.

Por favor entregue la forma completada dentro de 24 horas a \_\_\_\_\_\_\_\_\_\_\_\_\_. Por favor llame a \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ a \_\_\_\_\_\_\_\_\_\_\_, si tiena **cualquier** pregunta.

Gracias anticipadamente por su cooperacion y esperamos que se recupere pronto y regrese al trabajo.

Sinceramente

inc.

*Company Name*

**13C-S**

 13c

*Address*

*City, State, Zip Code*

**Return To Work Guidelines**

**for Employee**

Check when done

Report all injuries to your supervisor **immediately**. If medical treatment is needed and you have not predesignated a choice of physician, you should go to the physician predesignated by the company.

Complete the Claim for Workers’ Compensation Benefits and return it to your supervisor or personnel department as soon as possible.

Take the Physician’s Report form and Job Description Worksheet with you to your first medical appointment. Be sure the doctor returns the completed Physician’s Report form to you before leaving the appointment. Return the Physician’s Report form to your supervisor or personnel office the same day.

If you are not released for regular duty but are released for modified work, advise your supervisor and ask if modified duty appropriate to your restrictions is available.

If / when an appropriate modified job is developed, whether it is modification of your regular job or another job, you must report for work at the time designated by the company.

If you return to a modified job during the period of medical recovery, you must be certain not to exceed the restrictions assigned by your doctor. If your restrictions change you must notify your supervisor immediately and provide a copy of the doctor’s new release slip.

If you are taken off work completely or if no modified work is available, you must report your medical status to the office manager at least once a week.

Be sure the office always has your current mailing address and phone number.

*Company Name*

 13d

*Address*

*City, State, Zip Code*

**Guias Para Que Regrese al Trabajo**

**para el Empleado**

marcar cuando se completa

Reporte todos los accidentes de trabajo a su Superintendente **inmediatamente**. Si tratamiento medico es necesario y no ha escogido su medico adelantado, usted debe de ir al medico designado por la compania.

Complete la forma de Beneficios de Compensacion para el Obrero y entregaselo a su Superintendente o Departamento de Personal lo mas pronto posible.

Lleve la forma Reporte del Medico y la forma Descripcion de su Trabajo con usted a su primera cita medica. Asegurese que el medico le entrega la forma Reporte de Medico completado antes que se termine su cita. Entrege la forma Reporte de Medico a su Superintendente o Oficina de Personal ese mismo dia.

Si no le dan de alto para su tarea regular pero le dan de alto para trabajo modificado, aconseja a su Superintendente y pregunte si la tarea modificado segun sus restricciones es disponible.

Si y cuando un trabajo modificado apropiado se desarrolle, sea modificacion de su trabajo regular o otro trabajo, usted debe de ir al trabajo a la hora designado por su compania.

Si usted regresa a un trabajo modificado mientras lo estan tratando medicamente usted debe de cuidarse de no pasar los limites de las restricciones imponidos por su medico. Si su restricciones cambian usted debe de notificar a su Superintendente inmediatamente y proveer una copia del papel del medico que le da de alta.

Si lo quitan del trabajo completamente o trabajo modificado no es disponible, usted debe de reportar su condicion medica al director de la oficina por lo menos una vez a la semana.

Tenga por seguro que la oficina tenge su domicilio corriente y numero de telefono.

13d-S

**Job Description Worksheet**

Employee : Job Title : DOT Code (if known) : \_

Work Hours : Work Days : Date :

Employer : Address : Phone # :

**Job Summary** : (Brief general description of job)

Physical Demands

*Intermittent =* ***1-5 %*** *Occasional =* ***6-37 %*** *Frequently =* ***38-75 %*** *Continuous =* ***76-100 %***

**Sitting** - Percentage of time or hours per day

**Standing** (stationary) - Percent of time or hours per day, surface type, foot control

**Walking** - Percent of time or hours per day, intermittent/continuous

**Lifting** - Weight, type of object, frequency

**Carrying** - Weight, type of object, frequency, distance

**Pushing** - Weight, type of object, times per hour, distance

**Pulling** - Weight, type of object, times per hour, distance

**Bending** - Frequency, duration

**Kneeling** - Frequency, duration

 13e

Physical Demands- cont.

**Squatting** - Frequency, duration

**Climbing** - Frequency, height, slope, number of steps, on what

**Crawling** - Frequency, distance, surface

**Reaching** - Right, left, both, frequency, overhead, shoulder, chest, waist, below waist level

**Grasping** - Right, left, both, frequency, power/simple

**Manipulation** - Right, left, both, frequency, fine/gross

**Operating** - Machines, tools, equipment, vehicles

**Environmental Factors** - Is the job indoors or outdoors, extremes of cold, heat, humidity, noise, vibration, dust

**Comments** -

Employer Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_/\_\_\_/\_\_\_

Employee Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_/\_\_\_/\_\_\_

Instructions to Employee: Take this form to the doctor to complete the bottom portion. This form must be returned to your supervisor at  *Company Name*.

Name of employee:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical Treatment

Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ facility referred to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Supervisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**REPORT OF PHYSICIAN**

Please review the description of job duties and complete the below information for the employee to return to his/her supervisor immediately following examination.

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

[ ] **MAY NOW RETURN TO REGULAR WORK DUTIES WITHOUT RESTRICTION**

[ ]  **MAY RETURN TO WORK** *2 4 6 8* ( ) HOURS PER SHIFT

[ ] **MAY RETURN TO WORK WITH RESTRICTIONS**

***CAN NOT:***

 { } **sit**  anytime **/** prolonged more than \_\_\_\_\_minutes **/** hours of every \_\_\_\_\_hour**/**s

 { } **walk/stand** anytime **/** frequently **/** repetitively **/** # of times \_\_\_\_\_per hour / day

 { } **lift/carry** more than *10 20 30* \_\_\_\_*lbs*. anytime / frequently / repetitively

 { } **push/pull** more than  *10 20 30* \_\_\_\_*lbs*. anytime / frequently / repetitively

 { } **bend/stoop** anytime **/** frequently **/** repetitively **/** # of times \_\_\_\_\_per hour / day

 { } **kneel/squat** anytime **/** frequently **/** repetitively **/** # of times \_\_\_\_\_per hour / day

 { } **climb** anytime **/** prolonged more than \_\_\_\_\_minutes **/** hours of every \_\_\_\_\_hour**/**s

 { } **crawl** anytime **/** frequently **/** prolonged

 { } **reach** anytime **/** prolonged at **/** at or above **/** below shoulder **/** eye **/** head

 { } **grasp** power **/** simple right **/** left **/** both hands anytime **/** repetitively

 { } **manipulation** fine **/** gross right **/** left **/** both hands anytime **/** repetitively

 { } **operate** vehicles **/** moving equipment **/** other dangerous machinery

 { } **other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

[ ] **MAY NOT RETURN TO ANY WORK UNTIL**: *date* **\_\_\_/\_\_\_/\_\_\_**

[ ]  **NEXT APPOINTMENT**: *date* \_\_\_/\_\_\_/\_\_\_

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

 Physician’s Name Physician’s Signature Date

 (Please Print)

***HOW TO MODIFY JOBS CHECKLIST***

 13f

EVALUATE THE USUAL POSITION:

1. Define the PURPOSE of the position. What is to be accomplished? What is the by-product?
2. List the duties of the job that the employee is restricted from.
3. Discuss with the disabled employee how (if possible) s/he could do those duties differently.
4. If duties need to be eliminated, evaluate what duties could replace their absence to maintain a fully productive day.
5. Evaluate the cost of any alternatives.
6. Choose the most effective and cost efficient method available.

POSSIBLE MODIFICATION OPTIONS:

* Assistance of others / other workers.
* Reassignment of specific duties to others.
* Use of assistive devices.
* Purchase of special equipment.
* Job Station modification.
* Job Restructuring.
* Work Schedule changes.
* Job Sharing.
* Provide an Alternate Job appropriate to the restrictions.

Company Name

14

Address

City, State, Zip Code

**JOB OFFER**

\_\_\_/\_\_\_/\_\_\_ Claim # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Injury \_\_\_/\_\_\_/\_\_\_

Employee’s Name

Address

City, State, Zip Code

Dear ( *employee name* )

Your attending physician, Dr. ( *Dr.’s name* ), has provided a release for you to return to modified duty effective ( *date* ). A copy of the restrictions is attached. We have located a temporary position for you which your doctor has approved. The temporary position will be periodically reevaluated for appropriateness and availability.

The job assigned is ( *enter job title* ). A copy of the job duties is attached. Your rate of pay will be $\_\_\_\_\_\_ per ( *hour* / *week* / *month* ). Should this amount be less than your regular rate of pay, you may be entitled to receive a wage loss benefit, subject to statutory limits, from \_\_insurance company\_\_\_\_.

**Please report for work :**

Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours per *Day* / *Week* : \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *AM* / *PM* Report To : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If you receive this offer after the report to work date, you have **24** hours to contact ( *name of contact* ) by phone at ( *phone #* ) or in person between ( *enter hours available* ).

**FAILURE TO REPORT TO WORK COULD AFFECT TEMPORARY DISABILITY COMPENSATION AND COULD MEAN LOSS OF YOUR RE-EMPLOYMENT AND REINSTATEMENT RIGHTS, (SUBJECT TO APPLICABLE LAWS).**

We are looking forward to seeing you!

Sincerely

( *Name )*

Enc.

Company Name

15

Address

City, State, Zip Code

## OFERTA de TRABAJO

 / / Numero de Caso \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Fecha de Lastimadura \_\_\_/\_\_\_/\_\_\_

Employee’s Name

Address

City, State, Zip Code

Estimado  *,*

Su medico que lo atiende, Dr. , le ha dado permiso para que regrese a tarea modificada efectivo . Una copia de las restricciones viene atada. Le hemos conseguido una posicion temporal el que su medico ha aprobado. La posicion temporal sera revisada periodicamente para ver si sigue siendo apropiado y disponible.

El trabajo asignado es . Una copia de las tareas del trabajo esta atada. Su pago sera $\_\_\_\_\_\_ por . Si esta cantidad es menos de su pago regular, usted puede calificar para recibir el beneficio de pago suplemental, sujeto a limites estatutos, del (insert insurance company name).

**Por favor presentace para trabajar :**

Fecha : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Horas por *Dia* / *Semana* : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hora : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *AM* / *PM*  Presentace a : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lugar : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Numero de Telefono : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Si usted recibo esta oferta despues de la fecha para presentarse al trabajo, usted tiene **24** horas para ponerse en contacto con  por telefono a  o en persona entre las horas de \_ .

**FALTA de PRESENTARSE AL TRABAJO PUEDE AFECTAR SU BENEFICIO de INCAPACIDAD TEMPORAL Y PERDIDA DE SU EMPLEO Y DERECHOS de REINSTALACION EN SU TRABAJO, (SUJETO a LEYES APLICABLES).**

Espermos verlo pronto!

Sinceramente

Inc.

COMPANY NAME

 15-S

ADDRESS

CITY, STATE, ZIP CODE

 Employee :

 Date of Injury :

 Claim # :

**JOB OFFER ACCEPTANCE**

I have received a copy of the temporary position job offer dated \_\_ / \_\_/ \_\_ .

I accept the position as offered, \_\_\_\_ YES \_\_\_\_ NO

 employee name

 employee signature date

 supervisor signature date

COMPANY NAME

16

ADDRESS

CITY, STATE, ZIP CODE

 Empleado :

 Fecha de Injuria :

 Numero de Caso :

**Aceptacion de Oferta de Trabajo**

Yo he recibido una copia de la oferta de trabajo del puesto temporario con la fecha de \_\_ / \_\_/ \_\_ .

Yo acepto el puesto ofrecida, \_\_\_\_ SI \_\_\_\_ NO

 nombre del empleado

 firma del empleado fecha

 firma del superintendente fecha

*COMPANY ADDRESS CITY STATE ZIP*

 16-S

**MODIFIED DUTY / CHANGE OF DUTY - ASSIGNMENT FORM**

This form should be completed by the supervisor and the employee initially upon return to work to modified duty and again following each doctor’s appointment. Forward the signed form to the Personnel Department.

Employee **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Modified

Job Title **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Date **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician’s (please describe or attach report)

Restrictions **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

 Job Duties

Accommodating (please describe or attach report)

Restrictions **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Work

Schedule **:** # of days / week **:** \_\_\_\_\_ days of week **:** S M T W T F S ← (please circle one)

 # of hours / day **:** \_\_\_\_\_\_\_ from **:** \_\_\_\_ AM / PM to **:** \_\_\_\_ AM / PM

 Wages **:** **$**\_\_\_\_\_\_**.**\_\_\_ **/** hour, day, week, month ← (please circle one)

 Training (if any duties are other than those performed pre-date of injury)

Required **:**  # of hours required **:**\_\_\_\_\_\_ # of hours completed **:**\_\_\_\_\_\_

 Date of

Reevaluation **: \_\_\_ /\_\_\_ /\_\_\_**

**This has been reviewed by:**

Employee’s Signature Supervisor’s Signature

Date Date

*COMPANY ADDRESS CITY STATE ZIP*

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 **TAREA MODIFICADO / CAMBIO de TAREA - FORMA de ASIGNACION**

Esta forma debe de ser completada por el Superintendente y el empleado al principio de su regreso al trabajo a la tarea modificado y despues de cada cita con el doctor. Despues entrege la forma al Departamento de Personal.

Empleado **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Departamento **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Superintendente **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Titulo del Trabajo Fecha

Modificado **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ de Empezar **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Restricciones (por favor describa o atar el informe)

del Doctor **:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Tareas del Trabajo

Acomodido a las (por favor describa o atar el informe)

Restricciones**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Horario del (senala los dias que son apropiadas)

Trabajo **:** numero de dias / a la semana **:** \_\_\_\_\_ dias de la semana**:** D L M M J V S

 numero de horas al dia **:** \_\_\_\_\_\_\_ de **:** \_\_\_\_ AM / PM hasta **:** \_\_\_\_ AM / PM

Salario **:** **$**\_\_\_\_\_\_**.**\_\_\_alhora, dia, semana, mes ← (senala el que es apropiado)

 Instruccion (si los deberes son otras de esos ejecutadas antes de la fecha de Injuria)

Requeridas **:** numero de horas requeridas **:**\_\_\_\_\_\_ numero de horas completadas **:**\_\_\_\_\_\_

 Fecha de

Reexaminacion **: \_\_\_ /\_\_\_ /\_\_\_**

**Esta ha sido repasado por:**

Firma del Empleado Firma del Superintendente

Fecha Fecha

**17-S**