

# Sample 1

## [Company]

### Return-To-Work Program

#### Policy

The health and welfare of our employees is a top priority for [Company]. When one of our employees experiences a work-related injury or illness, we are committed to assisting employees to return to work as soon as possible.

We have implemented a Return-to-Work program that is designed to help return injured employees back to productive work quickly and aid in the healing process. The program depends on the team effort of the employee, supervisors, our insurance company, the treating healthcare provider, and company management.

Our Return-to-Work program incorporates temporary, transitional-duty jobs that consist of some type of modification to the original job, a different job, or several part-time tasks combined into one job. At management's discretion, and to the extent the employee's physical limitations and company operations permit, a transitional-duty job will be provided until the treating healthcare provider releases our employee to his or her full, regular work.

Through this program, the company will help the injured employee recover at a more rapid rate and minimize employee wage loss. At the same time, [Company] benefits from having our employees providing a service and contributing to the overall productivity of our business.

For additional information regarding our Return –To-Work Program, contact:

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

Phone: \_\_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

## **Objectives**

The Objectives of our Return-to-Work Program are to:

- Provide guidelines for administering early-return-to-work assignments;
- Assure employee welfare and job security by providing our employees with an opportunity to continue as valuable members of our team while recovering from a work related injury;
- Promote speedy recovery and rehabilitate our employee to a normal work status as effectively and as quickly as possible while keeping the employees' work patterns and income consistent;
- Complete the essential tasks of the employee's job function;
- Maintain communication among all parties to ensure quality medical care and to manage claim costs.

## **Scope and Conditions**

This program applies to all employees of [Company] who have an injury or illness that is compensable under the Workers' Compensation Laws of the [applicable jurisdictions] and that precludes the employee from performing any part of their normal work assignment, or anything less than, their normal work assignment.

Under the following conditions, [Company] will endeavor to provide transitional, modified duty to an employee who has experienced a work-related injury or illness:

1. The Company has productive, meaningful and manageable part-time or full-time work available, as determined by the Company.
2. The medical restrictions imposed by the treating healthcare provider are objective and have been clearly communicated to the Company.
3. The Company has had an opportunity to match the medical restrictions to a modified job/task(s).
4. The injured employee is able to perform available work in a manner that is cost effective, as determined by the Company.
5. The work can be performed safely within the medical restrictions and limitations identified by an appropriate healthcare provider.

## **Procedures**

Since work-related injuries and illnesses can result in varying degrees of disability, [Company] will consider both the degree of disability and the nature of the transitional work assignment in question. The Return-to-Work Program will address the following types of disability:

**Temporary Partial Disability** – The employee can eventually return to full capacity, but for a period of time cannot perform their normal duties at all or can only do limited types of work or work for a limited amount of time.

**Temporary Total Disability** – The employee cannot work but can eventually return to work with full or partial recovery.

**Permanent Partial Disability** – The employee is permanently and partially disabled, having achieved maximum possible improvement but not a full recovery.

[Company] will determine, based on the capabilities of the injured employee (as communicated by the treating healthcare provider) and the availability of work, if a transitional job assignment is available and if the employee is capable of performing the specific type of work involved. The company reserves the right to assign and transfer the injured employee to different jobs and will use the following guidelines to determine pay based on the work being performed:

### ***Partial Disability***

If the nature of the work-related disability is such that the employee can perform, to the company's satisfaction, their normal job assignment, they will be returned to their normal assignment and receive their normal rate of pay.

If due to the nature of the work-related disability the employee cannot satisfactorily perform their normal work assignments, but can perform other predetermined tasks, they will be paid at an appropriate rate that is not more than their normal rate of pay and not more than incumbents in that job. If the rate of pay is less than their regular earnings, the difference will be paid through workers' compensation benefits subject to jurisdictional requirements and limitations.

When an employee is placed in a transitional duty assignment, the position they previously occupied may be assigned on a temporary basis. If, after [60 working days or other time frame specified by the jurisdiction or labor contract] from the date of the work-related disability, the employee cannot return to their normal job assignment, that position will be posted as an available opening.

When the treating healthcare provider releases the employee to return to full time, full duty, they shall return to any available position that, at the discretion of the company, they are able to perform in a satisfactory manner.

### **Total Disability**

When the treating healthcare provider determines that a work related injury or illness precludes the employee from performing any work, they will be placed on workers' compensation disability leave. The employee will remain on leave until their condition reaches a point at which they can be returned to full time and full duty, or to a modified duty position.

If the position the employee normally performs is essential to maintaining normal operations, it may be assigned on a temporary basis. If, after [60 working days or other time frame specified by the jurisdiction or labor contract] from the date of the work-related disability, the employee cannot return to that position on a full time, full duty basis, the position will be posted as an available permanent position if it is going to be filled on a full time, full duty basis.

When the treating healthcare provider releases the employee to return to full time, full duty, they may return to a position that is available and that they can perform in a satisfactory manner. The rate of compensation may be adjusted based on the prevailing range of the position, the employee's previous level of compensation, or the demonstrated skills in the particular position.

### **Determination of Eligibility and Assignment of Transitional Modified Duty**

Before the acceptance and start of Modified Duty or Workers' Compensation benefits the;

1. Injured or ill employee must present to a company representative authorized by the injured employee to review protected medical information a written medical diagnosis and prognosis from the treating healthcare provider.
2. Company will communicate to the treating healthcare provider the availability of modified duty for the employee.
3. Company will provide to the treating healthcare provider a work status or modified duty evaluation form.
4. Treating healthcare provider will complete the work status or modified duty evaluation form and comment objectively on what medical restrictions apply and the employee "work ability".
5. Medical restrictions will be reviewed and matched to available job tasks to develop the modified duty assignment
6. Company will authorize the modified duty assignment.
7. Modified duty will be assigned in a job in any department at management discretion.
8. Supervisor will confirm knowledge of the medical restrictions and the scope of the modified duty.
9. Employee will be trained in the modified duty job assignment by the immediate supervisor of the modified job tasks.
10. Employee will accept modified duty assignments and perform the job tasks as instructed.

## General Considerations

Subject to the laws and regulations of [jurisdiction] and existing labor contracts, circumstances that can affect the modified duty program, employee work status and eligibility for temporary benefits include the following:

1. If a healthcare provider fails to objectively evaluate the feasibility of modified duty, the Company may still offer modified duty to the employee. The Company will offer to arrange for an objective medical evaluation. Failure to submit to an objective medical evaluation may result in loss of temporary disability benefits.
2. If an employee refuses to accept a modified work assignment, [insurance carrier] will be notified and action may be taken subject to the laws and regulations of [jurisdiction]. Actions may include termination of temporary disability benefits. Additionally, the employee may be required to assume a leave of absence status pending further information and action.
3. If an employee claims too much pain to continue modified duties, an acceptable medical reevaluation will be obtained to evaluate the complaints. No temporary disability status will be granted prior to an objective medical finding which substantiates the employees' complaints.
4. The healthcare provider is responsible for providing the Employee with a Work Status report following each medical reevaluation.
5. The employee will provide the Work Status report to the employee's immediate supervisor of the modified duty. No modified duty will be assigned without a Work Status form.
6. Employee performance will be evaluated in the modified duty assignments to the basic standards that apply to customary work. Failure to adhere to basic performance standards may jeopardize the modified work assignment, temporary disability benefits and job status.
7. Based on availability of work, on the job assignment or on the healthcare provider's recommendations, modified duties may be provided on a less than full time basis. In this case wages paid will be supplemented with partial temporary disability benefits.
8. It is possible that regular wages may not be paid for modified work. Should this occur, the wages paid will be supplemented with partial temporary disability benefits, subject to jurisdictional workers' compensation requirements and limitations.
9. The modified duty assignment will be periodically reviewed by the Company to determine the appropriate duration and activity.
10. Upon receipt of a written Work Status report indicating the employee is returned to full, unrestricted work, the modified duty assignment will terminate.

Jim Burkhart 9/17/04 4:08 PM

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The company reserves the right to assign, or not assign, a transitional, modified duty position; this practice lies solely at the discretion of the company. One or more modified duty assignments are not intended to be long-term. Subject to existing labor contracts, seniority will not be used in determining assignments, or their availability.

# Sample 2

## [Company]

### Return-To-Work Program

#### **Policy:**

[COMPANY] is committed to returning injured employees to modified or alternative work as soon after an injury or illness as possible. This will be done by temporarily modifying the employee's job or by providing the employee with an alternative position. The employee's medical condition along with any limitations or restrictions given by the attending healthcare provider will be considered as a priority when identifying the modified/alternative position.

#### **Purpose:**

This program is intended to provide our employees with an opportunity to continue as valuable members of our team while recovering from a work related injury. We want to minimize any adverse effects of an ongoing disability to our employees. This program is intended to promote speedy recoveries, while keeping the employees' work patterns and income consistent. At the same time, we benefit from having our employees providing a service and contributing to the overall productivity of our business.

#### **Scope:**

This program applies to ALL employees of [COMPANY].

#### **Responsibilities:**

##### **[COMPANY]**

[Coordinator] will handle all injuries and the duration of the disability.

[Coordinator] will act as a liaison between [COMPANY], the injured worker, the attending healthcare provider and [insurance carrier].

[Coordinator] will make sure the appropriate paperwork and forms have been properly handled and submitted to the appropriate parties.

[Coordinator] will monitor the modified/alternative work and gather any additional information that may be needed to properly handle the return to work efforts.

Note: Coordinator means an employee designated by the company and authorized in writing by the employee to receive and review private health information.

**All Supervisors/ Managers**

In the event of an injury or illness, the supervisor or manager will make sure that our employee receives first aid, or if necessary, proper medical treatment at our designated medical facility. If possible, the supervisor/manager will accompany the employee to the medical clinic. The attending healthcare provider will be notified on the first visit that [COMPANY] has a return to work program and that modified/alternative work will be provided. The supervisor/manager will work closely with [Coordinator] to coordinate the return to work efforts and will be responsible for introducing the employee back into the work place in the modified/alternative position. The supervisor/manager will make sure that the injured employee receives necessary assistance from co-workers and that the employee does NOT work outside of his/her restrictions. Monitoring for transition into full duty work will be the responsibility of the supervisor/manager.

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**Employees**

If an injury occurs on the job, the employee is required to report it to their supervisor/manager immediately. If the injury requires attention beyond first aid, the employee [must / should] proceed to our designated healthcare provider for occupational injuries or illnesses:

*Medical Facility  
Information*

If available, an employer representative will accompany the employee to the medical clinic. Together with the healthcare provider, the employee's physical restrictions and limitations will be discussed. All employees are expected to return to the worksite, if possible, the SAME day to report the healthcare provider's findings and to discuss modified or alternative work. This will enable all parties to be kept abreast of the employee's condition. Employees that have an injury or illness must report to the worksite, at the earliest possible time, following each provider visit to discuss his/her recovery.

Once an employee has returned to work, it is his/her responsibility to work within the physical limitations that the healthcare provider has given. The employee shall perform only those duties that are assigned to him/her. The employee must immediately notify his/her supervisor of any difficulty in performing the duties. The employee must also notify his/her supervisor in advance of any medical appointments (time allowances will be made for these appointments). Workers are encouraged to set medical appointments to minimize work disruptions. The employee must keep his/her supervisor/manager informed of the recovery process and the ability to perform modified/alternative work.

**Everyone**

[COMPANY] is committed to promoting in the best possible way a full recovery for any of our industrially injured employees. [COMPANY], along with [insurance carrier] are available to answer any question that may arise.

For additional information regarding our Return –To-Work Program, contact:

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

Phone: \_\_\_\_\_

# EMPLOYEE INJURY PACKET

Notice to Employees

Employee Injury and Return to Work Checklist

Introductory Letter to Healthcare provider

Checklist for When Employee Does Not Return to Work

Physical and Mental Demands of Employee's Current Job

Modified Duty Evaluation / Work Status and Return to Work Authorization  
Form

Temporary Modified Position Offer

[Post this notice in common employee areas and provide a copy to all workers at least annually]

# Notice to Employees

## Availability of Modified and Alternate Work

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We are committed to providing modified or alternate work whenever possible for our employees who are injured on the job. Early return-to-work has been shown to help injured workers achieve the most satisfactory recovery possible from an industrial injury. It also helps us control our workers' compensation costs.

If you are injured as a result of a work-related accident, please help us to help you by cooperating with our efforts to obtain information from your treating physician.

You may contact \_\_\_\_\_ if you have any questions regarding this policy.

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# EMPLOYEE INJURY AND RETURN TO WORK CHECKLIST

**Complete this for every work-related employee injury or illness**

Name of Employee \_\_\_\_\_ Date of Incident \_\_\_\_\_

- Send the employee to the proper medical facility.
- Send the following material with the employee:
  - Introductory Letter
  - Drug test authorization (if applicable)
  - Physical and Mental Demands of Employee's Current Job
  - Modified Duty Evaluation and Return to Work Form

***In case of emergency, do not delay treatment while these forms are gathered. Fax forms to doctor within 24 hours of the incident.***

Name of Clinic/Hospital \_\_\_\_\_

Disposition:   \_\_\_ Unrestricted work   \_\_\_ Modified work   \_\_\_ Not back to work

Fax or call in First Report of Injury to [insurance carrier].

- Fax letter to Claims adjuster.
- Physical and Mental Demands of Employee's Current Job.
- Additional comments on a separate sheet.
- Complete an accident investigation report.

## **IF EMPLOYEE COMES BACK TO WORK:**

- Meet with the employee to review workers' compensation benefits and answer questions.

## **IF EMPLOYEE COMES BACK FOR MODIFIED WORK:**

- Meet with the employee to review workers compensation benefits and answer questions.
- Explain the modified work limitations to the employee and explain how to get help with tasks that exceed these limitations.
- Diary your file weekly from the date of injury to review status.
- Continue to get feedback from the employee as to "how things are going."

## **IF THE EMPLOYEE DOES NOT COME BACK TO WORK**

- Refer to the "Checklist for When Employee Does Not Return to Work".

# CHECKLIST FOR WHEN EMPLOYEE DOES NOT RETURN TO WORK

Name of Employee \_\_\_\_\_ Date of Incident \_\_\_\_\_

This checklist must be completed for every employee injury or illness that involves time lost from work. Complete this checklist within 5 days of the injury.

**1. Telephone the injured employee.**

- Briefly explain workers' compensation benefits.
- Ask if he/she is satisfied with medical care. (If a negative response is received refer the issue to human resources for handling)
- Ask when the next doctor's appointment is scheduled.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Doctor: \_\_\_\_\_

- Ask if transportation is needed.
- Tell the employee you are anxious to have him/her back to work as soon as possible.
- Explain that modified work will be made available as soon as the doctor approves it.
- Explain that you expect the employee and his/her doctor to cooperate with the return to work plan.

**2. Telephone the treating physician.**

- Make sure the doctor has the Physical and Mental Demands of Employee's Current Job.
- Discuss the employee's normal job duties.
- Discuss any modified work that is available.
- Ask when the employee can be cleared for modified work: Date: \_\_\_\_\_

**IF THE EMPLOYEE DOES NOT COME BACK TO WORK WITHIN ONE WEEK OF THE INCIDENT:**

- Notify management that the employee is still off work.
- Set up a diary to make weekly contact with the employee, the treating physician, the claims adjuster, and management.
- Prepare a get-well card for management to sign and mail to employee.

**IF THE EMPLOYEE DOES NOT COME BACK TO WORK WITHIN ONE MONTH OF THE INCIDENT:**

- Notify management that the employee is still off work.
- Tailor a return-to-work plan in cooperation with appropriate personnel inside and outside the company and send to the healthcare provider for review.
- Prepare a get-well card for management to sign and mail to employee.

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Jim Burkhart 9/17/04 4:08 PM  
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Jim Burkhart 9/17/04 4:08 PM  
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[Current Date]

RE: [Injured Employee]

Dear [Healthcare provider],

[Company] has a modified duty, early return to work program that places employees into positions that are safely within their medical restrictions.

We are committed to bringing this employee back to a medically appropriate position while he/she recuperates from the effect of his/her injury. We will make every effort to modify the following job factors to accommodate whatever physical limitations the employee may have:

Marked are the areas for which job accommodations can be made

- [Job](#) Duties
- Hours
- Work Station
- Equipment
- Reassignment To Another Position
- Any of the Above
- Please Contact Me to Discuss [Name & Phone #]

Attached is a form describing the physical requirements of the employee's regular position. Please review and refer to this information.

Also attached is a Modified Duty Evaluation and Return to Work Authorization form. We would appreciate your taking a few moments to complete this form as it will help us to determine if a suitable temporary modified job is available or appropriate. Please return this information to:

[Contact person, Company & Address]

Thank you for your assistance with this important matter.

Sincerely,

# Physical and Mental Demands of Employee's Current Job

<b>Job Title:</b>		<b>Date:</b>	
<b>Employee Name:</b>		<b>Dept.:</b>	
<b>Preparer's Name/Title:</b>			
<b>Description of Job Duties: (Additional documentation may be attached)</b>			
<b>Outline "Essential" Job-Related Functions</b>			
1.			
2.			
3.			
4.			
<b>Physical Capabilities required to perform essential job functions</b>		<b>Mental Capabilities required to perform essential job functions</b>	
1.	5.	1.	5.
2.	6.	2.	6.
3.	7.	3.	7.
4.	8.	4.	8.
<b>Environmental Exposures</b>		<b>Protective Equipment</b>	
<small>Seldom – means the employee may be exposed up to 33% of the time, Often – means the employee may be exposed 34% to 66% of the time, Freq. – means the employee may be exposed more than 66% of the time.</small>			
	<small>Seldom</small>	<small>Often</small>	<small>Freq.</small>
	<b>S</b>	<b>O</b>	<b>F</b>
Dusts - Mists - Fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wet - Damp Surfaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extremes - Heat - Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemicals/Caustics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confined Spaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergens - Plants/Materials	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Physical and Mental Demands of Employee's Current Job

<b>Job Title:</b>			<b>Employee Name:</b>										
Hand manipulation required? <input type="checkbox"/> Yes <input type="checkbox"/> No (check A, B, C, D respectively)													
A. Simple Grasping?		Right:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Left:				<input type="checkbox"/> Yes	<input type="checkbox"/> No			
B. Power Grasping?		Right:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Left:				<input type="checkbox"/> Yes	<input type="checkbox"/> No			
C. Pushing & Pulling?		Right:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Left:				<input type="checkbox"/> Yes	<input type="checkbox"/> No			
D. Fine Manipulation?		Right:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Left:				<input type="checkbox"/> Yes	<input type="checkbox"/> No			
<b>Briefly describe if answering yes to any of the following questions.</b>													
Does the job require worker to reach above or below shoulder level?													
<input type="checkbox"/> Yes above		<input type="checkbox"/> No above		Frequency:									
<input type="checkbox"/> Yes below		<input type="checkbox"/> No below		Frequency:									
Does the job require use of worker's feet to operate foot controls or for repetitive movement?													
<input type="checkbox"/> Yes		<input type="checkbox"/> No											
Are there special visual or auditory requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Driving cars, truck, forklifts, other equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Walking on uneven ground? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Exposure to extremes in temperature or humidity? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Exposure to noise? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Intermittent means less than 66% of the time Continuous means more than 66% of the time													
Activity	Activity Level		Number of Hours Per Day										
	Cont.?	Inter.?	0	1	2	3	4	5	6	7	8	> 8	
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Percentage of Lifting Frequency			Weight					Percentage of Carrying Frequency					
%			10 lbs. or less					%					
%			11 lbs. to 20 lbs.					%					
%			21 lbs. to 40 lbs.					%					
%			41 lbs. to 55 lbs.					%					
%			56 lbs. to 75 lbs.					%					
Longest Distance Carried:													
Heaviest item carried, and how far:													

To Be Completed By The Employee	
Do you have any physical condition that may limit your ability to perform this job efficiently and safely? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain:	
_____	_____
<i>SIGNATURE OF EMPLOYEE</i>	<i>DATE OF SIGNATURE</i>
_____	_____
<i>SIGNATURE OF PREPARER</i>	<i>DATE OF SIGNATURE</i>

# [Company]

## Modified Duty Evaluation and Return to Work Authorization Form

Our company has a light duty and transitional work program that provides temporary jobs that injured employees should be able to safely perform during their recovery periods. Completion of this form will allow us to identify an appropriate assignment for this employee. Thank you for your cooperation and prompt response.

Evaluation Date \_\_\_\_\_ Date of Injury \_\_\_\_\_

Employee \_\_\_\_\_ Employer \_\_\_\_\_

Employer Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

Diagnosis \_\_\_\_\_

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

Date of Next Appointment \_\_\_\_\_

### Work Status

May Return to Regular Work without Restrictions: (Date)	May Not Return to Work Until: (Estimated Date)
May Return to Work with Restrictions: (Date)	Estimated Duration of Work Restrictions:

Prognosis \_\_\_\_\_

Referral To:

Healthcare provider \_\_\_\_\_

Physical Therapy - Location \_\_\_\_\_ No. of Treatments: \_\_\_\_\_

**Please fax this form to the attention of \_\_\_\_\_ at \_\_\_\_\_  
so our employee may return to work without delay.**

# [Company]

## Modified Duty Evaluation and Return to Work Authorization Form

### Work Restrictions

Restrictions apply to: Work \_\_\_ Home \_\_\_ Leisure \_\_\_

During the applicable 8-hour workday, this employee can:  
 Sit \_\_\_ hours Stand \_\_\_ hours Walk \_\_\_ hours

In terms of an applicable 8-hour workday, "occasionally" equals 1-33%. "Frequently" equals 34-66%, and "continuously" equals 67-100%.

Activity	Never	Occasionally	Frequently	Continuously
<b>Lift and Carry</b>				
Up to 10 pounds	_____	_____	_____	_____
11 – 25 pounds	_____	_____	_____	_____
26 – 35 pounds	_____	_____	_____	_____
36 – 50 pounds	_____	_____	_____	_____
51 – 75 pounds	_____	_____	_____	_____
76 – 100 pounds	_____	_____	_____	_____
Reach above shoulder level	_____	_____	_____	_____
<b>Push / Pull</b>	_____	_____	_____	_____
<b>Climb</b>	_____	_____	_____	_____
<b>Crawl</b>	_____	_____	_____	_____
<b>Squat / Kneel</b>	_____	_____	_____	_____
<b>Bend (Waist)</b>	_____	_____	_____	_____
<b>Bend (Neck)</b>	_____	_____	_____	_____
<b>Stoop / Crouch</b>	_____	_____	_____	_____
<b>Balance</b>	_____	_____	_____	_____
<b>Twist (Waist)</b>	_____	_____	_____	_____
<b>Twist (Neck)</b>	_____	_____	_____	_____
<b>Other</b> _____	_____	_____	_____	_____

Healthcare provider's Comments \_\_\_\_\_

\_\_\_\_\_

Healthcare provider Signature: \_\_\_\_\_ Date \_\_\_\_\_

[Current Date]

Name of employee:

Address:

City, state, zip:

Re: Availability of Temporary Modified Position

Dear: [Employee]

Your attending healthcare provider, \_\_\_\_\_, has released you for modified work. We have a temporary position for you that your healthcare provider feels you will be able to perform successfully. The availability of this position will be periodically reviewed. The position is:

[Describe position]

You will be receiving \$ \_\_\_\_\_ per (hour / week / month). (Insurance Company) will prorate your workers' compensation benefits if this is less than your regular wage, subject to statutory limits.

We ask that you report to work on:

Date \_\_\_\_\_ Hours per day/week \_\_\_\_\_

Time \_\_\_\_\_ (am / pm) Duration of job: \_\_\_\_\_ (days / weeks / months)

Report to \_\_\_\_\_ Phone \_\_\_\_\_

Location \_\_\_\_\_

If you receive this letter after the report-to-work date, please contact \_\_\_\_\_ within 24 hours.

***Failure to report to work could affect temporary disability compensation and could mean loss of your re-employment and reinstatement rights.***

Sincerely,

---

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

yes       no

---

Employees' Signature

## Authorization for Use and Disclosure of Private Health Information

I HEREBY AUTHORIZE THE HEALTHCARE PROVIDER IDENTIFIED BELOW, TO RELEASE THE PRIVATE HEALTH INFORMATION RELATED TO MY WORK-RELATED INJURY OR ILLNESS FOR WHICH TREATMENT BEGAN ON THE DATE INDICATED BELOW TO THE PERSONS SPECIFIED ON THIS FORM

Healthcare Provider: \_\_\_\_\_

Date Treatment Began: \_\_\_\_\_

Description of Private Health Information to be released:

Identification of person authorizing release: (The following information is needed for verification, Please complete all applicable items.)

Employee Name: \_\_\_\_\_

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

Social Security #: \_\_\_\_\_

Address: (include Zip Code) \_\_\_\_\_

I authorize the persons below to receive this information:

Company Name: \_\_\_\_\_

Company Representatives: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

This authorization expires: \_\_\_\_\_

I understand that I may revoke this authorization by sending a written request to the Human Resources Department of [Company] at [Address]. Any revocation will not be effective for any actions that may have already been taken.

SIGNATURE

I have read and understand the above information:

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

Signature of Employee: \_\_\_\_\_

Jim Burkhart 9/17/04 4:08 PM

Deleted: t