The THOMPSON Group

# Literature and Forms Regarding

Do you have an

# early-return-to-work

## program for your injured employees?



The longer an employee is off work following a work-related injury, illness, or disease, the more unlikely it is the injured employee will *ever* return to work. The Bureau of Labor Statistics reports …

- There is only a 50 percent chance an employee who is off work for SIX MONTHS will ever return to work.
- There is only a 25 percent chance an employee who is off work for A YEAR will ever return to work
- There is a significant chance an employee who is off work for TWO YEARS will *never* return to work.

An effective early return to work program can significantly reduce these alarming statistics and reduce your company's worker's compensation premium costs by decreasing disability periods.

An effective early-return-to-work program is proven to reduce worker's compensation costs by:

- Accelerating recovery;
- Accelerating the employee's return by addressing the physical, emotional, attitudinal, and environmental factors that accompany extended time off work;
- Reducing frequency of costly medical treatment;
- Lowering permanent disability awards;
- Reducing attorney involvement;
- Lowering worker's compensation settlements;
- Improving employee loyalty and morale; and
- Enhancing the employer's image in the community.


To learn more about the benefits of an early-return-to-work program and how to implement one, please email lwichmann@wbmi.com for your complimentary copy of West Bend Mutual's Early Return To Work Program.

The THOMPSON Group

# *RETURN TO WORK PACKET*

The following information is to assist you in implementing a Return To Work Program and keep track of all employee doctor visits, etc.

The following items are included in the packet:

- Sample Written Program, Page 1

- Accident/Incident Report, Page 3
- Two Sample Incident Forms:
  - Employee Incident Form, Page 5
    All employees should fill out in their own words exactly what happened. This information will be used by management to complete the First Report of Injury.
  - Sample Supervisor Investigation Form, Page 7
    All incidents should be investigated to find the root cause and prevention measures of the incident. This should be done immediately.

- Attending Physician Form, Page 8
  Employees take this form to the doctor for any work-related visit and are required to return the form immediately. On this form the doctor will indicate if there are work restrictions.

- Return To Work letter, Page 9
  This can be attached to the Physicians Form to let them know you have a Return To Work Program.

- Transitional Return To Work Log, Page 11
  This should be completed on all modified duty jobs. This form is completed by the supervisor and the employee. They review the jobs performed that day by the injured employee to make sure they are working within their restrictions and that nothing is aggravating the injury.

- Modified Duty Letter, Page 12
  This letter is sent to the injured employee in verification of the verbal modified duty job offer.

- Sample Modified Duty Sheets, Page 13

- COPY ALL FORMS FOR FUTURE USE

# *TRANSITIONAL RETURN TO WORK PROGRAM*

It is the goal of COMPANY NAME Transitional Return To Work Program to enhance the employee's rehabilitation and facilitate their return to work following a work related injury until the employee is able to return to his/her customary and usual duties.

## Procedure

1. An employee who has an incident while in the course of their employment is required to report their incident immediately to their supervisor and complete an employee incident report.

2. The initial report is then given to the RTW Coordinator to complete the First Report of Injury and submit it to NSI/West Bend Mutual Insurance within 24 hours

3. The injured employee's supervisor then conducts their investigation of the incident and documents the root causes, contributing factors and prevention measures. If medical attention is needed then the investigation can be completed later.

4. The employee is then given a cover letter to their physician, Attending Physician's Return To Work Recommendations Record, and a copy of their normal job description.

5. If an employee is taken off of work, the Return to Work (RTW) Coordinator notifies NSI/West Bend Mutual Insurance. The RTW coordinator also contacts the medical provider regarding return to work program.

6. Employees are required to bring their return to work slip(s) into the RTW Coordinator on the same day as their appointment unless their appointment is at the end of the business day. The following day would then be acceptable.

7. No employee can return to work without a completed release form. COMPANY NAME and NSI/West Bend Mutual Insurance will do everything possible to obtain a completed RTW form for an employee who is taken off of work.

8. Once a RTW is received, duties from the Transitional Return to Work Duties List will be identified based on their restrictions. A copy of the employee's duty list will be provided to them and their supervisor.

9. A verbal return to work offer will then be made to the employee by their supervisor. The supervisor will inform the RTW Coordinator once the verbal offer is made.

10. The verbal offer will then be followed by a written letter. The letter will be sent certified, return-receipt. It may also be given to the employee. All employees released for modified duty will receive a letter once they are released. There will be no exceptions.

11. The injured employee will complete the Temporary Transitional Return to Work Log (Attachment F) upon their return to work. The Log will be completed for every injured employee regardless of position, hours worked, or length of time he/she is on restricted work. There will be no exceptions.

12. Temporary Transitional Return to Work Logs must be forwarded onto the RTW Coordinator and retained in the employee's claim file for future reference. Also submit the form to NSI.

13. Employee's found working outside of their restrictions will be disciplined in accordance with our progressive disciplinary process. There will be no exceptions.

14. Modified duty will be provided for the maximum number of hours the employee is released by their physician.

15. The employee will be paid at their full rate of pay.

16. While on restricted work, for a work-related injury, the employee is responsible to report for all scheduled Physician and Therapy appointments. NAME AND TITLE OF COORDINATION must be informed of all appointments.

*An attempt should be made to schedule all appointments during non-working hours provided that the medical facility can accommodate those hours. Keep in mind that if appointments are scheduled during work, to speak to your employer regarding making up the time.*

17. Transitional job duties are temporary in nature and are subject for review on a weekly basis, as to their healing progress, reduction in restrictions, what jobs or duties are available and future medical treatment.

# ACCIDENT/INCIDENT REPORT

☐ Injury (work related) ☐ Illness (work related) ☐ Property Damage ☐ Incident

| Employee Name (First, Middle, Last) | Social Security Number | Sex ☐ Male ☐ Female | Employee Home Telephone Number |
|---|---|---|---|
| | | | |

| Employee's Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Age | Birthdate Mo. Day Yr. | Job Title | Department |
|---|---|---|---|
| | | | |

| Employee's Scheduled Work Week When Injured | Start Time AM PM | End Time AM PM | Hrs. Per Day | Hrs. Per Wk. | Days Per Wk. | Normal Full-Time Schedule for Injured's Work | Start Time AM PM | End Time AM PM |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

| Injury Date Mo. Day Yr. | Hour of Day AM PM | Last Day Worked Mo. Day Yr. | Start Date Mo. Day Yr. | ☐ No Lost Time ☐ Date Returned to Work Mo. Day Yr. ☐ Estimated Date of Return |
|---|---|---|---|---|
| | | | | |

Did employee seek medical attention? ☐ Yes ☐ No If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will the employee complete a drug screening? ☐ Yes ☐ No

Names of Witnesses (Attach witness statements.)

1. _____ 2. _____

Injured Employee's statement of what happened. (Identify circumstances and equipment involved.)

1. _____

2. _____

3. _____

4. _____

5. _____

What is the injury/illness? (Be specific.)

**Part of Body Affected**

- ☐ Eye
- ☐ Head
- ☐ Neck
- ☐ Back
- ☐ Arm
- ☐ Shoulder
- ☐ Fingers
- ☐ Leg
- ☐ Knee
- ☐ Hip
- ☐ Foot
- ☐ Wrist
- ☐ Hand
- ☐ Toes
- ☐ Ankle
- ☐ Elbow
- ☐ Trunk (Other than back)
- ☐ Other

**Type of Injury**

- ☐ Cut/Abrasion
- ☐ Bruise/Contusion
- ☐ Foreign Object
- ☐ Burn
- ☐ Break
- ☐ Sprain/Strain
- ☐ Exposure
- ☐ Repetitive Motion
- ☐ Other

I believe that the answers to the above questions are true to the best of my knowledge.

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____

Notified

# *EMPLOYEE INCIDENT REPORT*

Employee Name: _____ Facility: _____

Incident Date: _____ Incident Time: _____

Date Supervisor Notified: _____

Exact Body Part Injured: _____

Describe What Happened:

_____

_____

_____

_____

_____

_____

_____

_____

What do you think caused your incident?

_____

_____

_____

_____

What do you think could be done to prevent this type of incident from occurring again?

_____

_____

_____

_____

_____

Employee Name: _____

Date Report Completed: _____

# *SUPERVISOR INCIDENT INVESTIGATION REPORT*

Employee Name: _____

Incident Date: Incident Time:

Describe What Happened (Be specific, list *all* information):

_____

_____

_____

_____

_____

_____

_____

Witnesses: _____

_____

ROOT CAUSE of the Incident (the one cause, that if it was not present, the incident would never have happened):

_____

_____

_____

CONTRIBUTING CAUSE(S) of the Incident:

1. _____
2. _____
3. _____

Prevention measure(s) for ROOT CAUSE and CONTRIBUTING CAUSES:

| | Activity | Responsible Person | Target Date | Date Completed |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Person Completing Investigation: _____

Date Completed: _____

# ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Claim No.

Patient's Name (First) (Middle Initial) (Last) | Date of Injury/Illness

TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK

Diagnosis/Condition (Brief Explanation)

I saw and treated this patient on _____ (date) and based on the above description of the patient's current medical problem:

1. ☐ **Recommend his/her return to work with no limitations on** _____ (date)

2. ☐ **He/She may return to work on** _____ (date) **capable of performing the degree of work checked below with the following limitations:**

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one, which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. **In an 8 hour work day patient may:**
   a. **Stand/Walk**
   ☐None ☐1-4 hours ☐4-6 hours ☐6-8 hours
   b. **Sit**
   ☐1-3 hours ☐3-5 hours ☐5-8 hours
   c. **Drive**
   ☐1-3 hours ☐3-5 hours ☐5-8 hours
2. **Patient may use hand(s) for repetitive:**
   ☐Single Grasping
   ☐Pushing & Pulling
   ☐Fine Manipulation
3. **Patient may use foot/feet for repetitive movement as in operating foot controls:**
   ☐Yes ☐No
4. **Patient is able to:**

| | Frequently | Occasionally | Not At All |
|---|---|---|---|
| a. **Bend** | ☐ | ☐ | ☐ |
| b. **Squat** | ☐ | ☐ | ☐ |
| c. **Climb** | ☐ | ☐ | ☐ |
| d. **Twist** | ☐ | ☐ | ☐ |
| e. **Reach** | ☐ | ☐ | ☐ |

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ (date) **or until patient is re-evaluated on** _____ (date)

3. ☐He/She is totally incapacitated at this time. Patient will be re-evaluated on _____ (date)

**Physician's Signature** | **Date**

# *EARLY RETURN TO WORK PROGRAM*
## *SAMPLE LETTERS TO TREATING PHYSICIAN*

### SAMPLE 1

Dear Doctor:

You are treating our employee, (Employee's name) for an injury (he/she) has sustained at work on (date). (Company name) considers (Employee's name) a valuable resource and is committed to providing modified duty within (his/her) functional capabilities as soon as (he/she) is medically able.

We have a number of temporary, modified jobs available that have been designed to assist with our injured employee's rehabilitation until they are physically able to return to their normal full time positions. With your assistance, we would like to enroll (Employee's name) in our modified-duty program.

Enclosed is a Treating Physician's Physical Restriction Form. Please complete this form and return it to me as soon as possible. (You may either fax it or send it along with the employee)

We work closely with our employee's following their return to ensure they do not exceed their physical restrictions. I would be happy to discuss this with you further, or show you some of our modified duty job tasks if you care to visit.

We look forward to (Employee's name) return. Please contact me if you have any concerns or questions.

Thank you.

Sincerely,

.....

### SAMPLE 2

Dear Doctor:

Thank you for caring for our injured worker. (Company name) is committed to providing a safe, healthful work environment. Please assist us in keeping our employees productively employed while recovering from injury or illness.

It is our experience that the early return of an injured worker to productive modified work is emotionally and physically beneficial to them. EARLY RETURN TO WORK is successful when the injured worker is supported by the physician, (Company name) and NSI/West Bend Mutual Insurance.

Therefore, we will provide safe, meaningful modified work for every injured employee. We will be abide by all restrictions you deem necessary to facilitate the healing process.

Our goal is mutual. Your contribution is pivotal.

An Attending Physician's Return To Work Recommendations form has been included in this packet for your convenience. If you need or desire additional information or clarification, please call.

Sincerely,

# *RETURN TO WORK LOG*

The Return To Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty.

It helps eliminate potential conflicts should the question arise regarding the employee performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employee's restrictions to the log.
- Have employee write name on top of log and the Supervisor write their name.
- Remind employee it is their responsibility to follow the restrictions.
- Remind employee that the restrictions apply both and work and with non-occupational activities.
- Employee and supervisor review all tasks completed each day, indicate any concerns and everyone signs the form.

# RETURN TO WORK LOG

EMPLOYEE NAME: _____ SUPERVISOR: _____

| Date | Hours Worked In | Hours Worked Out | Tasks Performed | Comments Regarding Employee's Tolerance of Modified Duty Tasks | Employee Initials | Supervisor's Initials |
|---|---|---|---|---|---|---|
| Sunday / / | | | | | | |
| Monday / / | | | | | | |
| Tuesday / / | | | | | | |
| Wednesday / / | | | | | | |
| Thursday / / | | | | | | |
| Friday / / | | | | | | |
| Saturday / / | | | | | | |

I clearly understand, take responsibility for, and acknowledge the limitations my physician, Dr. _____ has placed on me while participating in this temporary transitional work program.

_____ _____

Employee Signature Date

# *SAMPLE LETTERS TO INJURED EMPLOYEE*

## SAMPLE 1 - CERTIFIED MAIL – RETURN RECEIPT REQUESTED

Dear (Employee):

Dr. (Name) has provided us with a release returning you to work with physical restrictions. (Please see attached form) or (list restrictions). We are very pleased to advise you that we have work available for you within these physical restrictions.

Effective (Date) and (Time) please report directly to (Name of Supervisor). The light duty job available is (Title), (Times/Shift) and the wage is ($).

We are looking forward to seeing you on the (Date).

Sincerely,
DATE

**EMPLOYEE NAME**
ADDRESS
CITY, STATE ZIP CODE

---

## SAMPLE 2

Dear EMPLOYEE NAME:

We have been informed that you are capable of performing modified work duties by _____, MD. We have work in our facility within your physical capabilities. The position is that of _____ and includes the following duties: PLEASE LIST DUTIES

This position will be for _____ hours per day, _____ days per week. The rate of pay will be _____ per hour. This work will be available to you beginning _____, so please report to work on _____ at _____ am/pm.
NAME OF PERSON is whom you will report to when you arrive at work.

I have attached a copy of your work/home capabilities form. Should you have any questions, please call me.

Sincerely,

NAME

Attachment

# *EXAMPLES OF MODIFIED DUTIES*

The following is a list of modified duty jobs during the rehabilitation period for C.N.A.'s, Dietary Aides, and Activity Aides. Please match the following with the specific job restrictions posed by the injured worker's physician.

## CNA's

1. Bathing residents at the bedside
2. Shaving residents
3. Oral hygiene (brushing teeth, dentures, etc.)
4. Hair care
5. Nail care
6. Foot care to residents in bed
7. Distribute resident mail/linen/bath towels
8. Assisting with meals
   - Passing and collecting trays
   - Feeding residents
   - Passing nourishment's and water
   - Clearing tables
9. Tracking resident's missing clothes
10. Making photocopies as needed
11. Answering phones
12. Clean overbed tables
13. Answer call lights
14. Wash wheelchairs, Geri chairs, commode chairs
15. Record resident intake and output
16. Tidy/clean resident closets and dressers
17. Take vital signs
18. Distribute Geri-pads or Depends
19. Label nursing supplies
20. 1:1 with residents

## Dietary Department

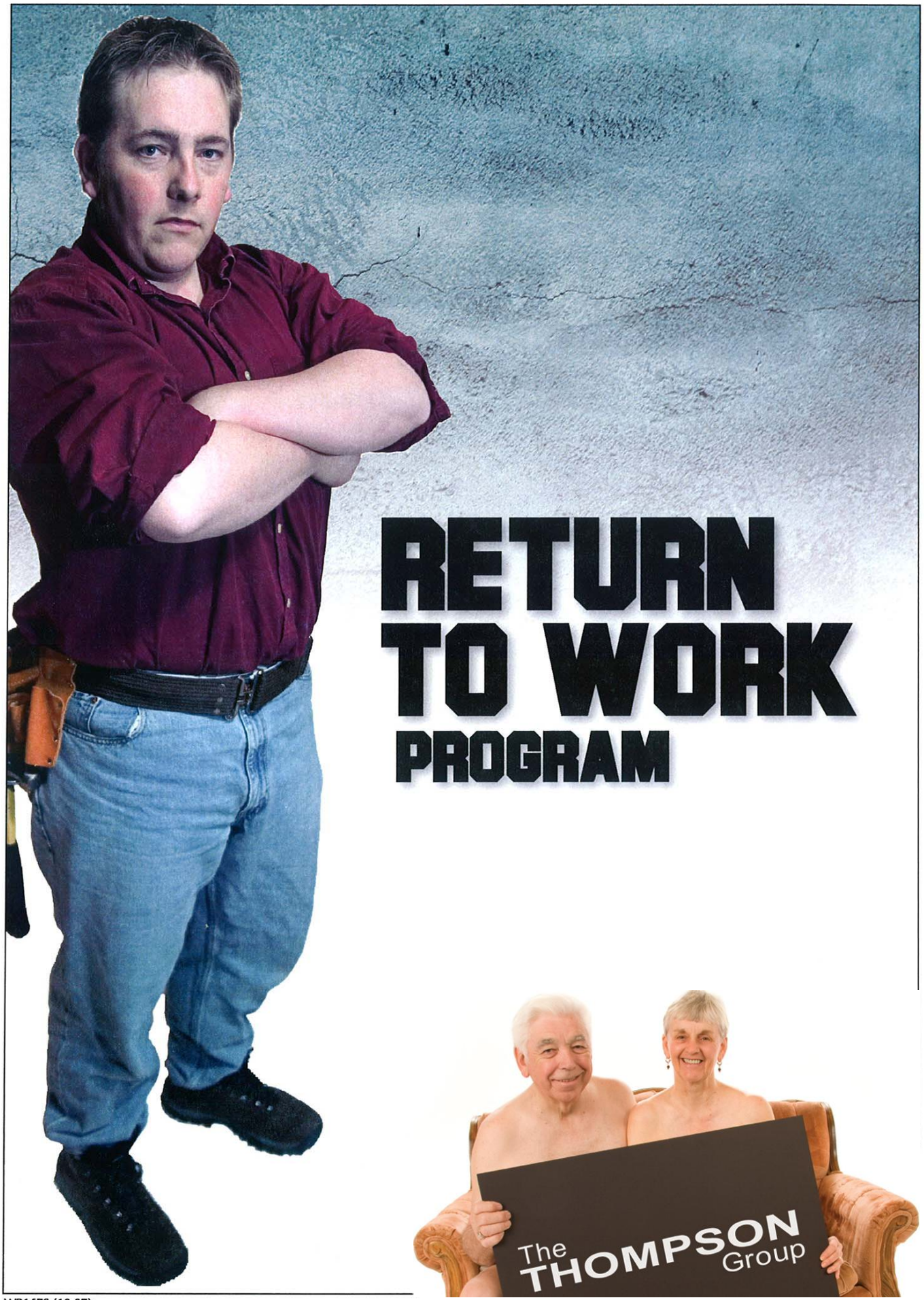
1. Update the Kardex
2. Update menus
3. Cut old menus up for scrap paper
4. Sort health care files and remove the outdate information
5. Thin out the care plan book in the diet office and place sheets in the health care files
6. Stamp the menu
7. Update the cart and table order charts
8. Update the polycose and power pudding lists
9. Rewrite the Supplement List
10. Date and distribute t he supplement list
11. Do the breakfast tally
12. Make the necessary menu changes
13. Refi ll cracker baskets
14. Pour mil k and juice
15. Refi ll cereal rack
16. Make toast
17. Help serve meals in the dining room but do not carry over ____lbs. at one time
18. Wash cou nters, clean cabinets
19. Chec k dates on food
20. Wash, cut up fruits and vegetables for meals

## Activity Department

1. Assist with bingo
2. 1:1 contact with residents (reading, self-care activities, crafts, etc.)
3. Assist with coffee break
4. Observe at second shift dining (observe residents & fill out checklist)
5. Provide structure, assistance, and guidance to residents in accomplishing activities

## Miscellaneous Duties

1. Bathing residents at the bedside
2. Shaving residents
3. Oral hygiene
4. Hair care for residents
5. Cleaning hairbrushes
6. Cleaning eyeglasses
7. Provide nail care to residents
8. Provide foot care to residents in bed
9. Assist residents with spiritual decisions
10. Read to the residents
11. Sitting and singing to the residents
12. Provide 1:1 with the residents
13. Assisting residents with activities while sitting at dining room table
14. Walking with residents who are independent with their ambulating
15. Assisting with meals
16. Meal preparation
17. Tracking/Labeling residents clothing
18. Making photocopies as needed
19. Wash wheelchairs, geri-chairs and bedside commode chairs
20. Record resident intake and output
21. Straightening closets and dressers
22. Take vital signs
23. Distribute geri-pads or depends
24. Checking expiration dates on food in kitchen and pantry
25. Washing refrigerator
26. Dust
27. Vacuuming
28. Cleaning toilets
29. Making beds
30. Assisting administrative personnel with non-confidential filing, typing, etc.

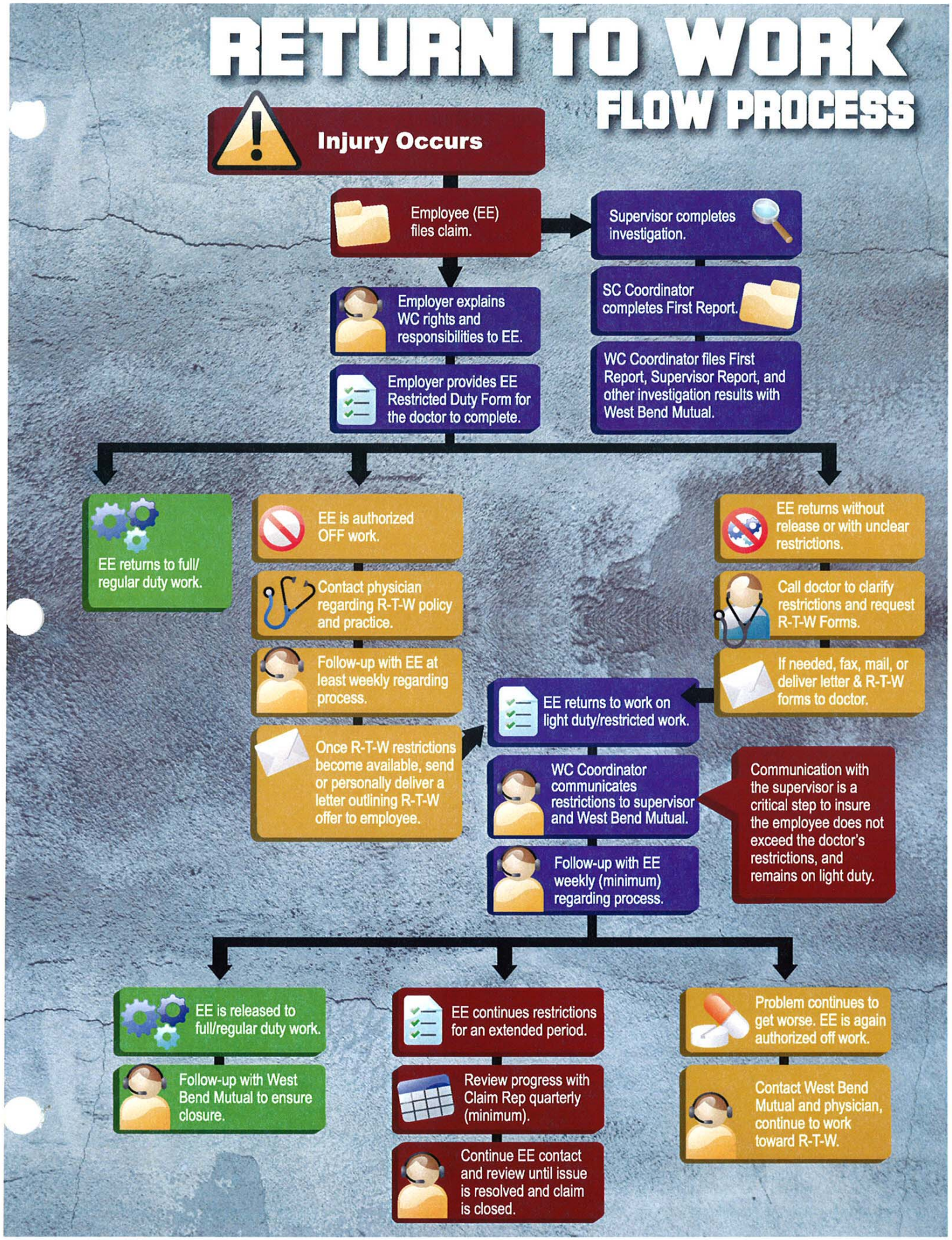


# RETURN TO WORK PROGRAM




WB1672 (10-07)

# RETURN TO WORK
## FLOW PROCESS



# Developing an Early Return to Work Program

Introduction

I. Injury Assessment

II. Identifying Light Duty Tasks
   a. Job Analysis Form

III. Developing a Program Statement
   a. Sample #1
   b. Sample #2
   c. Sample #3

IV. Procedures
   a. Sample Procedure
   b. What to Expect
   c. Medical Provider Checklist
   d. Employee Checklist

V. Forms
   a. Letter to Treating Physician
   b. Letter to Employee
   c. Attending Physician's Return to Work Recommendations
   d. Return to Work Log
   e. Accident / Incident Report (Supervisor's investigation report)

# INTRODUCTION

Recent national research concluded there's only a 50 percent likelihood an injured worker will return to his/her original job after just 12 weeks of disability. After about six weeks, the injured worker and the family begin to make fundamental adjustments to their lifestyle and finances. If the injured worker is off work more than a year, the likelihood of EVER returning to work is less than five percent.

A comprehensive early-return-to-work program will help minimize your company's workers' compensation costs by decreasing extended disability periods.

- Benefits of an Early-Return-To-Work Program:
- Promotes constructive relationships between company and employees, and often results in less system abuse;
- Improves the morale of your employees;
- Addresses the injured employee's fear of the unknown by maintaining a regular routine;
- Helps employees feel positive about their contributions and enhances self-esteem;
- Reduces the frequency of medical treatment because the employee feels he/she is recovering, not disabled;
- Discourages the notion that workers' compensation is a "paid vacation" benefit;
- Reduces litigation costs because employees on disability for extended periods often feel they "deserve a settlement" after they talk to family and friends;
- Reduces vocational rehabilitation costs by diminishing the employee's belief he/she will not be able to perform the same job again;
- Reduces permanent disability awards;
- Positively impacts experience modification insurance premium costs;
- Builds positive public relations for the company;
- Decreases turnover; and
- Reduces productivity loss.

# Injury Assessment

The primary goal of an early-return-to-work (ERTW) program is to provide work that's consistent with the physical restrictions of the employee who's recovering from a work-related injury or condition. An early-return-to-work program doesn't address permanent modified-duty replacement, which must be addressed on an individual case-by-case basis. Your goal is to have the injured employee return to his/her regular job as soon as soon as medically able.

**To determine your goals for an early-return-to-work program, start by evaluating your work-related accident history for any trends. Consider:**

- Types of injuries that have occurred;
- Area where injuries and accidents are occurring;
- Frequency of accidents; and
- Severity of accidents

**Use these sources to find this information:**

- OSHA 300 Log;
- West Bend Mutual Insurance Company loss runs;
- Your insurance agent; and
- West Bend Mutual Insurance Company's loss prevention representative.

# Identifying Light Duty Tasks

» There are several options to consider when identifying light-duty tasks for your injured employees:

- Modify current job tasks within physical capabilities;
- Combine job tasks from various jobs;
- Your light duty job tasks may only be available partial days;
- Gradual acclimation to a full schedule;
- Other locations and shifts; and
- Temporary placement in a non-profit organization.

» Be creative. Consider having the injured employee perform simple clean-up tasks or light maintenance.

» The work provided should be meaningful and safe.

» The Job Analysis Form details specific physical demands of a job task. You may use the Job Analysis Form to outline the specific tasks of a particular light duty job that already exists or complete it when creating a light duty job and provide it to physicians.

» You may also wish to complete a Job Analysis Form for every job within your organization. Some employers maintain completed Job Analysis Forms for ADA compliance issues. A sample form is included.

# JOB ANALYSIS

| Name | Claim Number |
|---|---|
| Employer | Address |

| Date of Hire | Date of Injury | Job Title | Check One ☐Skilled ☐Unskilled |
|---|---|---|---|

Training Required to Learn Job

| Was Employee Working as a Supervisor? ☐Yes ☐No | If Yes, Number of People Supervised | Employee Worked: ☐Alone ☐Small Group (3-5) ☐Large Group |
|---|---|---|

| Days Worked Per Week (Circle) | Hours Worked During Week |
|---|---|
| M Tu W Th F Sat Sun | From To Shift |

Work Breaks (Daily Rest Periods and Lunch)

| Morning | Lunch | Afternoon |
|---|---|---|
| — Minutes | — Minutes | — Minutes |

| Overtime Per Week Number of Hours | How Often | Was Employee Hired With Any Restrictions? (Check) ☐Yes ☐No |
|---|---|---|

If Yes, Specify

Body Movements – Amount Spent Each Day

Sitting % Standing % Walking %

| Check Appropriate Column | None | Occasionally (1/3 or Less) | Frequently (1/3 – 2/3) | Continuously (2/3 or more) |
|---|---|---|---|---|
| Reaching above shoulder length | | | | |
| Working with body bent over at waist | | | | |
| Working in kneeling position | | | | |
| Crawling | | | | |
| Bending, stooping, squatting | | | | |
| Repetitive foot movements as in foot controls – L/R or both | | | | |
| Climbing stairs | | | | |
| Climbing Ladders | | | | |
| Working with arms extended at shoulder level | | | | |
| Working with arms above shoulder height | | | | |

Height from floor of object to be reached and/or worked on (use space for drawing, if needed):

Object Height

| Weights Handled | Item | Alone or Assisted | Push, Pull Or Lift | Times Per Hour | Times Per Day | Times Per Week | Times Per Month |
|---|---|---|---|---|---|---|---|
| 1 – 10 lbs. | | | | | | | |
| 15 – 20 lbs. | | | | | | | |
| 25 – 35 lbs. | | | | | | | |
| 45 – 60 lbs. | | | | | | | |
| 65 – 80 lbs. | | | | | | | |
| 85 – 100 lbs. | | | | | | | |

☐No lifting required for this job.

| Hand Coordination Activities (Check Appropriate Column) | | | | |
|---|---|---|---|---|
| Movement Required | Tool/Machine | Right | Left | Both |
| Major hand | | | | |
| Fine Manipulation | | | | |
| Gross Manipulation | | | | |
| Simple Grasping | | | | |
| Power Grip | | | | |
| Hand Twisting | | | | |
| Pushing | | | | |
| Pulling | | | | |

| Tools Used By Worker | Weight | No. of Hands Needed To Move |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Objects Worker Must Move During Day | Weight | Distance | No. of Workers Needed To Move |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Physical Surroundings
Does Employee Work ☐Inside ___% ☐Outside ___%

Does Employee Walk On Uneven Ground? ☐Yes ☐No

Does Employee Work Around Moving Machinery? ☐Yes ☐No
Does Employee Drive Automotive Equipment? ☐Yes ☐No
If yes, describe:

| Does the Employee Come In Contact With The Following? (Indicate Type) | Yes | No | Type |
|---|---|---|---|
| Fumes | | | |
| Dust | | | |
| Mist | | | |
| Steam | | | |
| Strong Odors | | | |
| Poor Ventilation | | | |
| Air Conditioning | | | |

Characteristics Of Job That Cannot Be Modified By Employer For This Employee

Comments And/Or Observations

☐Job Site Evaluation Done ☐Narrative Discussion Only

| Name(s) of Person(s) Interviewed | Title |
|---|---|
| | |

| Person Completing Analysis | Title | Date |
|---|---|---|
| | | |

# Developing a Program Statement

The success of your early-return-to-work program depends on support and direction from senior management. A program statement publicized throughout your company is a way to not only demonstrate that support and commitment to the program, but to also provide clarity.

Here are several samples of program statements. Please take a few moments to review them. Your company's program should start with a written statement that reflects:

- Program objectives;
- Responsibilities;
- Your company's culture;
- Your company's attitude about early return to work;
- Top management's commitment;
- Compassion for employees; and
- Value of employees' contributions to the organization.

You may also want to have your corporate counsel review your statement.

# Early Return to Work Program Statement
## Sample #1

**GOAL:** To help the rehabilitation process and return our employees to productive work within their functional capacity as soon as possible following an injury or illness.

The management team at (ABC Company) supports our early-return-to-work (ERTW) program.

The ERTW program goes into effect immediately following a reported injury or illness. Planning for the employee's return requires the cooperation of the employee, treating physician, the employee's direct supervisor, management, and human resources.

Before the employee's return, the treating physician will provide specific information about the employee's physical restrictions. In addition, the treating physician will receive a written description of the light duty tasks assigned to the employee. The employee and supervisor will maintain and sign a daily log documenting the modified-duty jobs until the employee achieves a release to full duty. The employee must comply with the physical restrictions imposed by the treating physician and understand the physical restrictions also apply to non-occupational activities. The employee must remain under active medical treatment or a rehabilitation program while on physical restrictions. The employee is encouraged to communicate any problems or concerns to his/her supervisor.

We will make every attempt to return injured employees to their former departments, while accommodating temporary physical restrictions. It may be necessary, however, to return the employee to another department or shift. The supervisor of that department will be made aware of his/her physical restrictions and the light duty tasks assigned to this employee. The supervisor is also responsible for maintaining the Return To Work Log for the employee.

Ongoing communication with all parties is crucial to a successful ERTW program.

# Early Return to Work Program Statement
## Sample #2

**TO: ALL EMPLOYEES**

Our policy is to maintain an early-return-to-work (ERTW) program that addresses the uncertainty that often accompanies a work-related illness or injury. We consider our employees our most valuable resources and want them back to productive work as soon as medically possible. We believe an ERTW program helps the employee's rehabilitation process following an injury.

The goal of our company is to maintain a safe and healthy environment for all of our employees. Avoiding accidents and injuries involves the cooperation and awareness of everyone in the company. When an accident or injury occurs and the employee cannot perform his/her regular job, we have developed a procedure to accommodate the employee's physical restrictions.

You're an integral part of our success because open communication and support from everyone in the company is necessary to maintain a successful ERTW program. With your cooperation, everyone will benefit from this program.

# Early Return to Work Program Statement
## Sample #3

**Policy:**

It is the policy of (ABC Company) to accommodate temporary work assignments to employees who have been injured and are unable to immediately perform their regular job duties.

**Purpose:**

To clarify the procedure that is to be followed by the injured employee entering the early- return-to-work (ERTW) program. This is a transitional position intended to eventually return an employee to full-time regular work.

**Scope:**

This policy applies to all employees.

**Responsibility:**

The manager or supervisor will determine eligibility for participation in the ERTW program and will coordinate the temporary work assignment.

**(ABC Company's) Commitment:**

(ABC Company) is committed to providing our employees with the opportunity to return to work as soon as their abilities allow them to contribute to the organization. Our ultimate goal is to return the injured employee to work within 24 hours following the injury or release from the treating physician. Obviously, this goal may not be attainable, but each case must be addressed with the appropriate sense of urgency and with open communication by all parties.

Most importantly, management believes our employees are important resources, not expendable commodities. Every effort will be made to help with their rehabilitation.

# PROCEDURES

» Develop an employee handbook that details what to expect following a work-related injury.

- Sample included on page 4-4.
- Provide to all new employees or provide to injured worker at time of injury.

» Develop accident investigation procedures for supervisors.

- Complete these procedures within 24 hours of the occurrence.
- Complete the accident investigation form and have the employee sign off.
- Review and reinforce your early-return-to-work (ERTW) program immediately following the injury, and highlight the benefits and responsibilities.

» Develop claim reporting procedures for employees to follow.

- All injuries must be reported to the direct supervisor immediately.
- Place posters outlining procedures in conspicuous areas such as lunch or break rooms.
- Reinforce these procedures periodically.

» Identify medical providers with these qualities:

- Commitment to providing quality medical care; and
- A willingness to work with you and your ERTW program.

» Develop claim reporting procedures.

- Complete the Employer's First Report Of Injury.
- Report to West Bend Mutual Insurance Company within 24 hours of the occurrence.

» Place the ERTW program procedures in writing.

- Outline the goals and parameters of the program.
- Outline responsibilities of all parties.
- Maintain communication with the injured employee.

» Designate a point person (Workers Compensation coordinator) for:

- First aid and transportation for medical treatment, if necessary;
- Accident investigation;
- Completing First Reports of Injury;
- Providing the injured employee with forms for the treating physician;
- Follow up with the medical provider;
- Follow up with the injured employee;
- Follow up with West Bend Mutual Insurance Company's claim representative; and
- Maintaining communication with the injured employee.

» Include timeframes for:

- Employee accident reporting;
- Supervisor accident investigation and reporting;
- Modified duty program time limit (i.e., modified duty will not exceed 12 weeks in duration);
- Modified duty ceasing when the injured employee is released without physical restrictions; and
- Employer reserving the right to evaluate the injured employee's continued participation in the modified duty program if the employee isn't making progress toward full duty.

» Communicate to management and employees.

- Develop communication protocols for maintaining contact with all parties following an injury.

» Coordinate with West Bend Mutual Insurance Company's claim representatives.

- Avoid duplication of efforts.

» Additional considerations for developing procedures:

- Identify a number of light duty tasks and develop written descriptions using the Job Analysis format;
- Rate of pay for the light duty tasks may be based on the particular job description and adjusted according to the modified duty task. If the employee is earning less than the average weekly wage rate at the time of injury, West Bend Mutual will make up the difference to bring the injured employee's benefit level up to what it would be if the employee were on temporary total disability (TTD). This is called Temporary Partial Disability (TPD).
- The light duty job may be on any reasonable shift or location.
- If you don't have a light duty position available on your premises, consider an arrangement for temporary placement with a non-profit agency such as Goodwill Industries.
- Be sure to place parameters on the duration of your light duty job tasks.
- Permanent modified duty should be considered on an individual case-by-case basis.
- Build employee accountability into your program.
- Have the employee sign a Return To Work Agreement. This outlines the responsibilities and obligations for participation in the ERTW Program.
- Open communication and close monitoring are necessary to a successful program.

# Sample Procedure

1. An injury that requires medical treatment is sustained.
2. The injured employee immediately reports to the supervisor per company policy.
3. The supervisor completes an investigation, including completing a report with the injured employee within 24 hours following the injury.
4. The injured employee is informed by the company that every effort will be made to accommodate any physical restrictions.
5. The supervisor provides the employee with Attending Physician's Return to Work Recommendation report and arrangements are made to transport the employee to a medical provider, if necessary.
6. The supervisor reports the injury to appropriate personnel (Workers' Compensation coordinator).
7. The Workers' Compensation coordinator reports the injury to West Bend Mutual Insurance Company within 24 hours.
8. Within 24 hours, the employee returns with the completed Attending Physician's Return to Work Recommendations report, or the medical facility faxes it faxed to the Workers' Compensation coordinator. If neither occurs, the employer should call the medical facility to advise that light duty is available for the employee and to secure a release from the treating physician. The company may also fax another form and ERTW letter to the treating physician, then follow up.
9. The injured employee is released to return to work with physical restrictions.
10. The Workers' Compensation coordinator contacts the supervisor and reviews the physical restrictions.
11. The WC coordinator then determines if work is available within the restrictions. If so,
12. The WC coordinator will contact the employee with the date and time to report back to work. Follow up in writing (see sample letter), using certified mail, return receipt requested.
13. West Bend Mutual Insurance Company's claim representative will call the Workers' Compensation coordinator within 24 hours after receiving the First Report of Injury. The claim rep will coordinate activities.
14. The employee reports for work on the specified date and time as directed by Workers' Compensation coordinator.
15. Together the employee and supervisor review and sign the Return to Work Agreement. Together the employee and supervisor review the physical restrictions and the Return to Work Log, and determine where the log will be maintained for daily entries.
16. Daily entries are made to the Return to Work Log and initialed by both the employee and supervisor.
17. The employee and supervisor sign the Return to Work Agreement.
18. If all goes well, the employee follows up with the treating physician for a full duty release.

# What to Expect Following a Work-Related Injury

The purpose of this simple communication piece is to provide employees with a general understanding of what they can expect and what is expected of them following a work-related injury. Each employee should receive a copy when hired.

Its purpose is to prevent litigation by helping to ease the anxiety associated with incurring a work-related injury or illness. It should be a simple and easy reference, no more than one page. If it's too lengthy, the employee may not read it or may not understand it.

In addition, it's important for employees to understand where Workers' Compensation insurance comes from. Is it employer paid or state funded? It's important that employees understand the state mandates what can and cannot be paid under Workers' Compensation. To avoid potential malingering or an incentive for employees to remain off work, be careful not to provide too much information or interest in Workers' Compensation benefits.

While you can't prevent all losses, you can control and mitigate losses through early return to work (ERTW), early medical intervention, and prospective communication. Here are other suggestions you may wish to include in this handout:

**Reporting:**

- Reporting requirements of employees
- Who to report the injury to
- Importance of timely reporting
- Reporting requirements for employers – jurisdictional

**Medical treatment:**

- Communication expectations with employer

**RTW:**

- General statement of company's policy or philosophy (one or two sentences)
- Procedures (forms for treating physician to complete, returning the form, etc.)
- Employee's responsibilities

**Insurance Company:**

- Name and address
- Advise the employee that cooperation with the insurance claim representative is necessary. The employee may be asked to provide a recorded statement of what occurred.

**Benefits:**

- State Mandated
- How temporary total disability (TTD) is calculated-in general terms:
  two-thirds of average weekly wage at time of injury.
- Keep it very general. For instance, Workers' Compensation provides wage replacement while in the healing period, as well as payment for reasonable and necessary medical expenses. Provide just enough information to take the worry out of experiencing a compensable injury. Be careful not to provide incentives for the employee to stay off or seek retraining-vocational rehabilitation-Loss of earning benefits.

**Employer Contacts:**

- Any questions should be directed to company personnel. Telephone number and contact name are optional.

# Medical Provider

Developing a long-term relationship with a medical provider whose services and philosophy mirrors your company's needs is particularly helpful when implementing your early-return-to-work program. The provider's staff should become familiar with your operations and early-return-to-work philosophy. Schedule a meeting with essential contacts to establish procedures and a communication plan. If possible, schedule a tour of your facility.

While you can't direct medical treatment in Wisconsin, you can suggest facilities to your employees as long as they're aware the final choice is theirs.

Attached is a checklist you may wish to use when identifying a medical provider.

# Prospective Medical Provider Check List

1. Location(s)
2. Clinic hours
3. Average waiting times for pre-placement physicals, drug screening, walk-ins
4. Affiliation with hospital emergency room for after-hours medical treatment and testing
5. Information management
6. Services available
7. DOT drug/alcohol screening and physicals
8. Staff case manager
9. Role of case manager
10. Use of staff physical therapists
11. Specialties available (orthopedic, neurology, occupational, hand specialists)
12. Outsourcing of specialties
13. Philosophy regarding early return-to-work process
14. On-site analysis conducted by staff, including physicians
15. Will physicians view videotapes?
16. DOT and non-DOT fees
17. Will physicians agree to meet with nurse case managers?
18. Does the medical provider participate in your PPO network?

# Return to Work Checklist for Employee

1. Report directly to your supervisor.
2. You must wear appropriate personal protective equipment.
3. Review all physical restrictions with your supervisor.
4. Review the return to work log with your supervisor.
5. Complete and initial the return to work log each day.
6. Remember that physical restrictions apply to non-occupational activities, as well.
7. Do not exceed your physical restrictions while on light duty. If anyone asks you to do so, advise management immediately.
8. You must be under active medical treatment and/or rehabilitation while on light duty.
9. You must have a release from your treating physician before returning to your regular job.
10. Communicate any problems or concerns to your supervisor or to management.

# Sample Letter to Treating Physician

Dear Doctor:

You're currently treating our employee, (employee's name), for an injury (he/she) sustained at work on (date). (Company name) considers (employee's name) a valuable member of our company and is committed to providing modified duty within (his/her) functional capabilities as soon as (he/she) is medically able.

A number of temporary, modified jobs are available to assist with our injured employee's rehabilitation until (he/she) is physically able to return to a normal full-time position. With your help, we'd like to enroll (employee's name) in our modified-duty program.

Enclosed is a Treating Physician's Physical Restriction Form. Please complete this form and return it to me as soon as possible by faxing it or sending it along with the employee. Our fax number is (fax number).

We work closely with our employees following a return to ensure they don't exceed their physical restrictions. I would be happy to discuss this with you or show you some of our modified-duty job tasks if you care to visit.

We look forward to (employee's name) return. Please contact me if you have any concerns or questions.

Thank you.

Sincerely,

# Attending Physician's Return to Work Recommendations Record (Form WB-531)

Any injured employee who is required to seek medical attention for an injury or illness must provide a physician's authorization (WB-531) and/or release to return to work. This will ensure the treating physician addresses the issue of early return to work.

When using the attending physician's form, we suggest you ...

» Provide the injured employee with a copy of the form to deliver to the treating physician. This form will provide you with:
- Documentation of lost time;
- Return-to-work date;
- Physical restrictions;
- Duration of restrictions; and
- Re-evaluation date.

» You may also want to provide the physician with a copy of your company's early return to work policy.

» Require the employee to return the form to a designated contact at your company.

» Inform the employee that every possible effort will be made to safely return him/her to work immediately following the injury.

» You may wish to fax the form directly to the treating physician, along with a letter outlining your goals (see sample included in this packet).

» Provide a copy of the form to your West Bend Mutual claim representative.

# ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Claim No.

Patient's Name (First) (Middle Initial) (Last) | Date of Injury/Illness

**TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK**

Diagnosis/Condition (Brief Explanation)

I saw and treated this patient on _____ (date) and based on the above description of the patient's current medical problem:

1. ☐ **Recommend his/her return to work with no limitations on** _____ (date)

2. ☐ **He/She may return to work on** _____ (date) **capable of performing the degree of work checked below with the following limitations:**

☐ **Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.

☐ **Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

☐ **Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

☐ **Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.

☐ **Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.

☐ **Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8 hour work day patient may:
   a. Stand/Walk
      ☐None ☐1-4 hours ☐4-6 hours ☐6-8 hours
   b. Sit
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
   c. Drive
      ☐1-3 hours ☐3-5 hours ☐5-8 hours
2. Patient may use hand(s) for repetitive:
   ☐Single Grasping
   ☐Pushing & Pulling
   ☐Fine Manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls:
   ☐Yes ☐No
4. Patient is able to:

| | Frequently | Occasionally | Not At All |
|---|---|---|---|
| a. Bend | ☐ | ☐ | ☐ |
| b. Squat | ☐ | ☐ | ☐ |
| c. Climb | ☐ | ☐ | ☐ |
| d. Twist | ☐ | ☐ | ☐ |
| e. Reach | ☐ | ☐ | ☐ |

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ (date) or until patient is re-evaluated on _____ (date)

3. ☐ **He/She is totally incapacitated at this time. Patient will be re-evaluated on** _____ (date)

Physician's Signature | Date

**EARLY RETURN TO WORK PROGRAM**

**RETURN TO WORK AGREEMENT**

TO BE USED WHEN INJURED EMPLOYEE IS RELEASED TO RETURN TO WORK WITH PHYSICAL RESTRICTIONS

List of work restrictions:_____

_____

_____

I understand I am to follow these restrictions at all times.

I understand that if I am ever asked to perform work outside of the above restrictions, I will decline the task and notify my supervisor.

I understand that if I experience difficulty with the assigned task, I will notify my supervisor.

| | |
|---|---|
| _____ | _____ |
| Name of employee (please print) | Name of supervisor (please print) |
| _____ | _____ |
| Signature of employee | Signature of supervisor |
| _____ | _____ |
| Date | Date |

Modified Duty Time Frame_____to_____(not to exceed 12 weeks)

If the employee is not making progress toward returning to full duty, as deemed by (employer name), he/she will be evaluated for continued participation in the light duty program.

# Return to Work Log (Form 4140-14)

The Return To Work Log is an efficient method used to monitor and document the specific tasks your employees perform while on modified duty. It will help eliminate potential conflicts should questions arise about the employee performing work in excess of his/her restrictions. It also serves as a daily reminder to the employee and his/her supervisor that restrictions are in effect.

- A supply of these forms should be centrally located and provided to each department supervisor or manager.
- Attach a copy of the employee's physical restrictions to the log.
- Have the employee write his/her name on top of the log.
- Be sure the employee knows it is his/her responsibility to follow the physical restrictions.
- Remind the employee that physical restrictions also apply to non-occupational activities.
- The employee must complete the daily log and initial it each day.
- The employee's supervisor must initial the log each day.

# RETURN TO WORK LOG

EMPLOYEE NAME _____ SUPERVISOR _____

| Date | Hours Worked In | Out | Tasks Performed | Comments Regarding Employee's Tolerance of Modified Duty Tasks | Employee Initials | Supervisor's Initials |
|---|---|---|---|---|---|---|
| **Sunday** / / | | | | | | |
| **Monday** / / | | | | | | |
| **Tuesday** / / | | | | | | |
| **Wednesday** / / | | | | | | |
| **Thursday** / / | | | | | | |
| **Friday** / / | | | | | | |
| **Saturday** / / | | | | | | |

I clearly understand, take responsibility for, and acknowledge the limitations my physician, Dr. _____ has placed on me while participating in this temporary transitional work program.

_____ _____

Employee Signature Date

# SUPERVISOR'S INCIDENT REPORT

☐ Injury (work related) ☐ Illness (work related) ☐ Property Damage ☐ Incident

| Employee Name (First, Middle, Last) | Social Security Number | Sex ☐ Male ☐ Female | Employee Home Telephone Number |
|---|---|---|---|
| | | | |

| Employee's Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Age | Birthdate Mo. Day Yr. | Job Title | Department |
|---|---|---|---|
| | | | |

| Employee's Scheduled Work Week When Injured | Start Time AM PM | End Time AM PM | Hrs. Per Day | Hrs. Per Wk. | Days Per Wk. | Normal Full-Time Schedule for Injured's Work | Start Time AM PM | End Time AM PM |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

| Injury Date Mo. Day Yr. | Hour of Day AM PM | Last Day Worked Mo. Day Yr. | Start Date Mo. Day Yr. | ☐ No Lost Time ☐ Date Returned to Work Mo. Day Yr. ☐ Estimated Date of Return |
|---|---|---|---|---|
| | | | | |

Did employee seek medical attention? ☐ Yes ☐ No If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will the employee complete a drug screening? ☐ Yes ☐ No

Names of Witnesses (Attach witness statements.)
1. _____ 2. _____

Injured Employee's statement of what happened. (Identify circumstances and equipment involved.)

_____

_____

_____

How could this incident have been prevented?

_____

_____

_____

What corrective action has been taken?

_____

_____

_____

What is the injury/illness? (Be specific.)

**Part of Body Affected**

- ☐ Eye
- ☐ Head
- ☐ Neck
- ☐ Back
- ☐ Arm
- ☐ Shoulder
- ☐ Fingers
- ☐ Leg
- ☐ Knee
- ☐ Hip
- ☐ Foot
- ☐ Wrist
- ☐ Hand
- ☐ Toes
- ☐ Ankle
- ☐ Elbow
- ☐ Trunk (Other than back)
- ☐ Other

**Type of Injury**

- ☐ Cut/Abrasion
- ☐ Bruise/Contusion
- ☐ Foreign Object
- ☐ Burn
- ☐ Break
- ☐ Sprain/Strain
- ☐ Exposure
- ☐ Repetitive Motion
- ☐ Other

_____ _____

I believe that the answers to the above questions are true to the best of my knowledge.

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____
Notified