Sample Injured Worker Return-To Work/ Modified Duty Policy Statement

(To appear on company letterhead)

Injured Worker Return-To-Work/Modified Duty Policy Goal

A Return-To-Work Policy has been adopted by (Name of Company) with the goals of reducing the costs associated with workplace injuries by facilitating the speedy recovery of injured workers.

Policy

It is the Company's policy to return injured workers to productive work, although not necessarily to their pre-injury duties, as early as possible during their recovery. This type of work is often referred to as "modified-duty work" or "bridge work." The Company has adopted this policy because employees who remain off work for long periods of time not only affect the Company's productivity and workers compensation costs, they often experience slow healing and loss of self-esteem. Within the requirements of their treating medical providers, the limitations of the law, and the economic and physical limitations of our own properties, the Company will make every effort to provide meaningful work wherever and whenever possible. Any recovering employee who is offered a physician-approved, modified-duty position will be required to accept the offer.

(Signed by the President of Company)

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Sample Absentee Call-In Data Form

Name of Employee ______________________________ Date ______________

Address of Employee ____

Telephone number of Employee ____________________ Time of call ______________

Cause of injury or illness: ____

____

Events leading to and following the accident: ______________________________

____

____

____

Has the employee received medical treatment? ________ Yes ________ No

If so, did the employee receive treatment from the medical care provider? ______________

____

(If the employee has not received treatment but will be doing so, it should be suggested that the employee visit the company's medical care provider.)

If the employee is planning to receive treatment from other than the company's medical care provider, when will they receive treatment and what is the name and address of the treating physician/facility?

____

____

If the employee has received treatment, what is the diagnosis? ______________________

____

Does the employee anticipate missing any work? ________ Yes ________ No

If so, when does the employee expect to be able to return to full duties? ______________

Other comments: ____

____

____

Form completed by ______________________________________

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Sample Physician Notification Letter

(To appear on company letterhead)

This letter explains the company's *Return-To-Work Program* and requests that the physician complete an *Injured Worker Physical Capabilities Form*.

Doctor's Name
Address
City, State, Zip Code

Re: *(Injured Worker's Name)*
Date of Accident:

Dear Dr. ____________________________________

We believe it is of benefit to both our injured workers and our company to return workers to a productive job as soon as possible after an injury. Therefore, we are working with the above named injured worker regarding suitable modified work designed to comply with your specific limitations. Our approach to assigning modified work is as follows:

1. We ask the treating medical care provider to complete the attached *Physical Capabilities Form*.

2. When we receive this form from you, we fashion a job or variety of jobs which do not exceed the limitations you have set.

3. We then submit the appropriate job to you for approval. Upon your approval, we return the employee to modified work.

I have enclosed a *Physical Capabilities Form* for your completion. I look forward to its timely receipt so that we can begin to work on *(Injured Worker's Name)'s* behalf to identify appropriate work. Please call me if you have any questions.

Sincerely,

(Signed by the Program Coordinator)

CC: Great American Insurance Company®, Claims Department

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Sample Physical Capabilities/ Physician Evaluation Form

(To appear on company letterhead)

Patient Name ______________________________ Claim Number ____________________

Please indicate your opinion of the patient's maximum physical capabilities during a normal workday. Make this evaluation based on your objective findings. This assessment will be used to determine if a position within these limitations can be found. Your help in completing this evaluation is greatly appreciated.

Circle the number of total and consecutive hours for each applicable category.

Action	**Total Hours**									**Consecutive Hours**								
Sitting	0	1	2	3	4	5	6	7	8	0	1	2	3	4	5	6	7	8
Standing	0	1	2	3	4	5	6	7	8	0	1	2	3	4	5	6	7	8
Walking	0	1	2	3	4	5	6	7	8	0	1	2	3	4	5	6	7	8

Circle/highlight the number of repetitions for each applicable category.

Action	**Repetitions**				
Bending	0	1-15	16-30	31-60	61+
Twisting	0	1-15	16-30	31-60	61+
Squatting	0	1-15	16-30	31-60	61+
Climbing	0	1-15	16-30	31-60	61+
Crawling	0	1-15	16-30	31-60	61+
Reaching	0	1-15	16-30	31-60	61+
Pushing	0	1-15	16-30	31-60	61+

Fill in the weight and circle/highlight the number of repetitions for each category.

Action		**Repetitions**				
Lifting	_____ lbs.	0	1-15	16-30	31-60	61+
Carrying	_____ lbs.	0	1-15	16-30	31-60	61+
Arm/Both	_____ lbs.	0	1-15	16-30	31-60	61+
Left Arm	_____ lbs.	0	1-15	16-30	31-60	61+
Right Arm	_____ lbs.	0	1-15	16-30	31-60	61+
Hand/Both	_____ lbs.	0	1-15	16-30	31-60	61+
Left Hand	_____ lbs.	0	1-15	16-30	31-60	61+
Right Hand	_____ lbs.	0	1-15	16-30	31-60	61+

Other Arm/Hand Restrictions: ____

Leg/Foot: ____________________ Perform repetitive movements: _________ Yes _________ No

Other Leg/Foot restrictions: ____

____

____

Patient (is/is not) restricted by environmental factors, including temperature, humidity, dust, other:

____

Patient's (medication, treatment) may affect his/her ability to work: __________ Yes __________ No

If yes, please comment: ____

____

____

Are these capacities: Permanent ___________ Temporary ____________

If temporary, for how long do you feel those capacities will be in effect? ______________________

Will this injury likely result in permanent disability? __________ Yes __________ No

In consideration of the above restrictions, the patient is: (circle one)

Disabled   Released (restricted work)   Released (regular work)

Patient will be seen again for re-evaluation on _____________________

The patient can return to restricted or modified work on ____________________

The patient can return to regular work on ______________________

Remarks: ____

____

____

____

____

______________________________ ______________________________
Physician Name *Physician Signature*

____
Date

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Sample Job Physical Assessment Form

(To be completed by the employer/supervisor)

Location Address ____

Job Title/Description ____

Prepared by ______________________________ Date______________

The Job Physical Assessment is an objective evaluation of maximum physical job requirements of the stated job during a normal workday. Please consider each action category carefully, and objectively mark the appropriate measurement for the activity.

Circle the number of total and consecutive hours for each applicable category.

Action	Total Hours									Consecutive Hours								
Sitting	0	1	2	3	4	5	6	7	8	0	1	2	3	4	5	6	7	8
Standing	0	1	2	3	4	5	6	7	8	0	1	2	3	4	5	6	7	8
Walking	0	1	2	3	4	5	6	7	8	0	1	2	3	4	5	6	7	8

Circle/highlight the number of repetitions for each applicable category.

Action	Repetitions				
Bending	0	1-15	16-30	31-60	61+
Twisting	0	1-15	16-30	31-60	61+
Squatting	0	1-15	16-30	31-60	61+
Climbing	0	1-15	16-30	31-60	61+
Crawling	0	1-15	16-30	31-60	61+
Reaching	0	1-15	16-30	31-60	61+
Pushing	0	1-15	16-30	31-60	61+

Fill in the weight and circle/highlight the number of repetitions for each category.

Action		Repetitions				
Lifting	_____ lbs.	0	1-15	16-30	31-60	61+
Carrying	_____ lbs.	0	1-15	16-30	31-60	61+
Arm/Both	_____ lbs.	0	1-15	16-30	31-60	61+
Left Arm	_____ lbs.	0	1-15	16-30	31-60	61+
Right Arm	_____ lbs.	0	1-15	16-30	31-60	61+
Hand/Both	_____ lbs.	0	1-15	16-30	31-60	61+
Left Hand	_____ lbs.	0	1-15	16-30	31-60	61+
Right Hand	_____ lbs.	0	1-15	16-30	31-60	61+

Comments: ____

____

Supervisor's signature ______________________________ Date ______________

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Sample Physician Job Approval Letter

(To appear on company letterhead)

This letter informs the treating medical care provider of what modified job tasks have been assigned to the injured worker. It also requests the treating medical care provider's approval to allow the injured worker to perform tasks. Attached to this letter should be the *Job Physical Assessment Form* which will describe the physical requirements of the job in detail.

Doctor's Name
Address
City, State, Zip Code

Re: *(Injured Worker's Name)*
Date of Accident:

Dear Dr. ____

We understand that (Injured Worker's Name) will be unable to return to their usual and customary employment for some time due to their work injury. We have located a light/modified duty job that we believe is compatible with the restricted physical capacity of (Injured Worker's Name).

Attached is our detailed assessment of the physical requirements of the job we propose to assign *(Injured Worker's Name)*.

Attached is our detailed assessment of the physical requirements of the job. We propose to assign (Injured Worker's Name) to that job provided you feel it is within his/her physical limitations. This job would require (Injured Worker's Name) to work from (time) to (time), (#) days a week. Their duties would include (list duties here). The job is available (date).

We will provide the position described above for our employee as long as the light duty is available, or until you release them to their regular duties.

For your convenience, I have attached a form letter for you to indicate your advice/approval on this matter. Thank you for your assistance.

Sincerely,

(Signed by the Program Coordinator)

CC: Great American Insurance Company®, Claims Department

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Sample Physician Job Approval Reply Letter

(To appear on company letterhead)

This letter acts as the medical care provider's authorization approving the injured worker's modified duty assignment.

Your Business Name
Your Street Address
City, State, Zip Code

Re: *(Injured Worker's Name)* Early Return To Work
Date of Accident:

1. I (agree/do not agree) with the tasks as listing in your letter dated (date of letter) as being within (Injured Worker's Name)'s physical capabilities.

2. If not in agreement, please indicate which tasks are inappropriate: ______________________________

____

____

3. *(Injured Worker's Name)* will be able to start the light-duty program on: __________________________

4. Other Comments: ____

____

____

Name ____

Signature ____

Date _____________________________

CC: *(Injured Worker's Name)*
Great American Insurance Company®, Claims Department

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Sample Modified Duty Availability Letter

(To appear on company letterhead)

This letter serves as notification to the injured worker of his/her modified duty assignment, as approved by their treating medical care provider.

Injured Worker's Name
Address
City, State, Zip Code

Dear *(Injured Worker's Name)*

It is the Company's policy to return injured employees to productive work as early as possible during their recovery. Your treating medical care provider has agreed that you can return to work to perform the following job: ____

____

You are to report *(Supervisor's Name)* on this date and time: __________________________

Please contact me *(phone number)* if you have any questions or if you cannot return to work as indicated.

Sincerely,

(Signed by the Program Coordinator)

CC: *(Medical Care Provider's Name)*
Great American Insurance Company®, Claims Department

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Sample Employee Injury Tracking Sheet/Log

(To appear on company letterhead)

Name of Employee ____

Address ____

Telephone Number of Employee ______________________

Cause of Injury or Illness ____

Date	Purpose of Contact	Comments

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