# Stay at Work or Return to Work Program Template

## Sample Return to Work Forms

|  |  |
| --- | --- |
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# A1. Sample Injury Management Policy – Large Employer

## Injury Management Policy

Between

**Company name**

And

**Union/Labour representatives**

Name of Company is committed to the well-being and rehabilitation of all employees unable to perform their normal duties as a result of being injured on or off the job or recuperating from an illness. Labour and management representatives in cooperation have developed a Injury Management Program, incorporating modified/alternate return to work duties, to meet this objective.

Stay at Work or Return to Work is individualized for each employee and is supported by medical documentation. This program provides for a timely job modification/placement to a temporary or permanent disabled employee who cannot perform regular duties as a consequence of an occupational or non-occupational injury/illness. The alternative job will be productive and valued work that can be performed safely and without risk of re-injury or aggravation to the disability, or risk to other employees.

It is (name of company)’s intent that this program will be compatible with current statutory laws and collective agreements with any exceptions being mutually agreed to by both labour and management representatives.

All employees who become injured/disabled, regardless of cause, will be eligible and encouraged to participate in the program.

The intent of this Injury Management Program is to provide us with a guideline. It should be recognized that this program does not cover all circumstances.

It is also our intent to maintain and expand the cooperative efforts of management, labour and the occupational health and safety committee towards the awareness of accident and injury prevention.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Signatures:** |  |  |  |
|  | **Management Representative** |  | **Union/Labour Representative** |

# A2. Sample Injury Management Policy – Small Employer

## Injury Management Policy

**Company name**

Name of Company is committed to the well-being and rehabilitation of all employees unable to perform their normal duties as a result of being injured on or off the job or recuperating from an illness.

Stay at Work or Return to Work is individualized for each employee and is supported by medical documentation. This program provides for a timely job modification/placement to a temporarily or permanently disabled employee who cannot perform regular duties as a consequence of an occupational or non-occupational injury/illness.

The alternative job will be productive and valued work which can be performed safely and without risk of re-injury or aggravation to the disability, or risk to other employees.

It is Name of Company’s intent that this program will be compatible with current statutory laws.

All employees who become injured/disabled, regardless of cause, will be eligible and encouraged to participate in the program.

It is also our intent to maintain and expand our cooperative toward the awareness of accident and injury prevention.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Signatures:** |  |  |  |
|  | **Owner** |  | **Worker Safety Representative** |

# B1. Sample Stay at Work or Return-To-Work Brochure

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **An Exciting New Program!** |  | **What’s Involved?** |  | **Benefits?** |  | **Special Terms** |
|  |  | The company is starting a new rehabilitation initiative for employees recovering from illnesses and injuries. A component of the company General Safety Program, the Stay at Work or Return to Work Program helps convalescing employees ease back into the workplace by adapting schedules and duties to their level of ability. |  | The Stay at Work or Return to Work Program is designed to help convalescing employees regain both their health and their place in society – this is achieved by restoring their social, vocational and economic capacities through and early and safe return to work. The premise of the program is that employees are our most vital and valuable resource.  **Our Approach**  The Disability Management Committee developed a Stay at Work or Return to Work Program policy framework for the organization to use. The Stay at Work or Return to Work Program will work very closely with various rehabilitation programs. The program will involve new responsibilities, tasks and work for managers, union reps, supervisors and of course, the injured or ill employee themselves. |  | Getting back to work after a serious illness or injury is an important stage of rehabilitation. In our culture, work is a big part of life and a major source of self-esteem. To be able to Stay at work or a prompt return to work helps prevent the loss of friends, professional contacts and occupational skills that re essential to our well being, not only on the job, but in every aspect of our lives.  One of the main goals of the Stay at Work or Return to Work Program is to help sick and injured employees maintain their identity as valued members of the company and keep them from thinking of themselves as patients. Recovery not only *seems* to go faster, it is faster – and more effective – when sick and injured employees keep in touch with their job and their colleagues while under medical care, and plan to go back to work as quickly as possible. |  | **Return to Work:**  The reintegration of convalescent employees to the jobs they did before their illness or injury.  Convalescent employees can return to work very quickly if they can be assigned duties that are modified to accommodate their level of ability. The return to work is easier and more successful if it begins as soon as possible in a sick or injured employee’s convalescence, with activities that fit within their restrictions while still challenging them.  **Stay at Work or Modified Duties:**  Changes in a job’s tasks, work schedules, or both. Modifications are typically made to work areas, equipment, production quotas, schedules and organization of tasks. Convalescing employees using the Stay at Work Program will preferably be assigned modified duties in their own section. |

# C1. Sample Stay at Work or Return to Work Policy – Large Employer

In fulfilling this workplace’s commitment to providing a safe and healthy working environment, a Return to Work program has been established for workers who sustain workplace injuries.

Name of Company/Organization undertakes to accommodate injured workers through early assistance, rehabilitation and placement, where possible, to the benefit of the entire workplace. This program provides gradual and consistent rehabilitation to all injured workers.

Name of Company/Organization will work toward facilitating injured workers to an appropriate and timely Stay at Work or Return to Work in pre-injury positions. If this is not possible, the original department will make every effort to place workers in suitable, alternative positions. In the event that alternative positions are not available within the original department, every reasonable attempt will be made to find appropriate positions in other departments. All attempts to place the worker in other area must be done, in an appropriate manner, in cooperation with manager, health care providers, Workers’ Compensation Board representatives, union representatives and the worker.

Any personal information received from or about the worker will be held in the strictest confidence. Information of a personal nature will be released only if required by law or with the approval of the worker, who will specify the nature of any information that may be released and to whom it can be released.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Date:** |  |
| **Signed:** |  | **Date:** |  |

# C2. Sample Stay at Work or Return to Work Policy – Small Employer

In fulfilling our commitment to providing a safe and healthy workplace, Stay at Work or Return to Work programs have been established for all workers who sustain a workplace injury.

Name of Company will undertake to accommodate injured workers through early assistance and appropriate accommodation. This will include gradual and consistent modification for all workers required.

Name of Company will assist workers in a timely and appropriate return to their pre-injury jobs. If this is not possible, temporary alternate or modified duties will be arranged whenever possible.

All personal information about the injured worker will be held in the strictest confidence and only returned with the permission of the worker or by statutory requirement.

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Date:** |  |

# C3. Sample Stay at Work or Return to Work Policy – Large Employer

## Statement of Commitment

Between

**Company name**

And

**Union/Labour representatives**

Name of Company and its Employees/Union(s) Name are committed to the prevention of workplace injury and/or illness. In the event of injury or illness, Company name and its employees/union(s) name is committed to minimizing the impact of the injury and ensuring a safe, timely return to the workplace.

Name of Company and its Employees/Union(s) Name are committed to a workplace program that is designed to assist employees to Stay at Work or Return to Work safely and in a timely manner, to assist with treatment and recovery and reduce time away from the workplace.

The program is:

* voluntary
* respectful of all employees
* flexible
* specifically designed for each employee’s abilities
* within the scope of the collective agreement(s)
* individualized, with programs planned and documented with time lines
* communicated and promoted though the company.

Safe and timely Return to Work recognizes that while an employee cannot perform the full range of regular duties, meaningful, productive work can be performed.

We are committed to the principles of the program, and will work cooperatively towards the successful, safe return to work for all employees of the company.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Signed at |  | This |  | Day of |  | 20 |
|  | | CEO |  |  | | Chief Steward |
| On behalf of the employer | |  |  | On behalf of employees | |  |

# C4. Sample Stay at Work or Return to Work Policy – Small Employer

## Statement of Commitment

**Return To work**

Name of Company is committed to the prevention of workplace injury and/or illness. In the event of injury or illness, Name of Company is committed to minimizing the impact of the injury and ensuring a safe, timely return to the workplace. Name of Company is committed to a workplace program that is designed to assist employees to Stay at Work or Return to Work safely and in a timely manner, to assist with treatment and recovery and reduce time away from the workplace.

The program is:

* voluntary
* respectful of all employees
* flexible
* specifically designed for each employee’s abilities
* individualized, with programs planned and documented with time lines.

Safe and timely Return to Work recognizes that while an employee cannot perform the full range of regular duties, meaningful, productive work can be performed.

We are committed to the principles of the program, and will work cooperatively towards the successful, safe Return to Work for all employees of the company.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Signed at |  | This |  | Day of |  | , 20 |
|  | |  |  |  | |  |
| Owner | |  |  |  | |  |

# D1. Sample Physical Demand Analysis

A Physical Demand Analysis describes the physical requirements of the job or position. It focuses on the strength, flexibility, sensory and environmental requirements or conditions of specific tasks. It should be completed for the employee’s present position and modified duty positions available so that it may be used by the health care provider to determine if an employee is physically able to return to work on regular duties or modified duties.

|  |  |  |  |
| --- | --- | --- | --- |
| Job or Position: |  | Date form completed: |  |
| Regular hours of work/day: |  | Completed by: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **During a regular work day, the employee must circle number of hours and indicate if intermittent [I] or constant [C] for each activity.** | | | | **Lifting Requirements** | | | | |
|  |  |  | |  | Never | Occasionally | Frequently | Continuous |
| **Sit** | 0 1 2 3 4 5 6 7 8 hours | I / C | | **Up to 10lbs** |  |  |  |  |
| **Stand** | 0 1 2 3 4 5 6 7 8 hours | I / C | | **11 to 24lbs** |  |  |  |  |
| **Walk** | 0 1 2 3 4 5 6 7 8 hours | I / C | | **25 to 34lbs** |  |  |  |  |
| **Drive** | 0 1 2 3 4 5 6 7 8 hours | I / C | | **35 to 50lbs** |  |  |  |  |
| **Bend** | 0 1 2 3 4 5 6 7 8 hours | I / C | | **51 to 74lbs** |  |  |  |  |
|  | 0 1 2 3 4 5 6 7 8 hours | I / C | | **75 to 100lbs** |  |  |  |  |
|  |  |  | | **Above 100lbs** |  |  |  |  |
| **Job Requirements** | | | |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |
|  | **Squatting** | |  | **Carrying Requirements** | | | | |
|  | **Kneeling** | |  |  | Never | Occasionally | Frequently | Continuous |
|  | **Bending** | |  | **Up to 10lbs** |  |  |  |  |
|  | **Twisting** | |  | **11 to 24lbs** |  |  |  |  |
|  | **Reaching** | |  | **25 to 34lbs** |  |  |  |  |
|  | **Crawling** | |  | **35 to 50lbs** |  |  |  |  |
|  | **Ladder Work** | |  | **51 to 74lbs** |  |  |  |  |
|  | **Stair Climbing** | |  | **75 to 100lbs** |  |  |  |  |
|  | **Walking on rough ground** | |  | **Above 100lbs** |  |  |  |  |
|  | **Working at heights** | |  |  |  |  |  |  |
|  | **Exposure to heat or cold (circle)** | |  |  |  |  |  |  |
|  | **Exposure to dust, fumes or gases** | |  | **Pushing Requirements** | | | | |
|  | **Exposure to high humidity** | |  |  | Never | Occasionally | Frequently | Continuous |
|  | **Exposure to noise** | |  | **Up to 10lbs** |  |  |  |  |
|  | **Repetitive movements** | |  | **11 to 24lbs** |  |  |  |  |
|  | **Work above shoulder** | |  | **25 to 34lbs** |  |  |  |  |
|  | **Work below shoulder** | |  | **35 to 50lbs** |  |  |  |  |
|  |  | |  | **51 to 74lbs** |  |  |  |  |
|  |  | |  | **75 to 100lbs** |  |  |  |  |
|  |  | |  | **Above 100lbs** |  |  |  |  |
|  |  | |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |

# D2. Sample Potential Light Duties

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Food and Beverage** | |  |  |  |  |
|  | Polish Cutlery and Glassware |  | Pre-set Room Service tables & trays |  | Confirm reservations |
|  | Fold Napkins |  | Service audits, silent guest audits |  | Market analysis, e.g. get menus from other restaurants |
|  | Answer telephones / fold menus / change menu covers |  | Health and Safety checklists |  | Update log books |
|  | Light cleaning such as dusting and cleaning equipment |  | Sort guest comments |  | Reservation statistics |
|  |  |  |  |  |  |
| **Housekeeping** | |  |  |  |  |
|  | Quality Checks |  | Clock times |  | Fold laundry bags |
|  | Collect dirty robes and tie robes |  | Fold guest comment cards |  | Safety inspections |
|  | Clean outside of guest doors |  | Dust hallways |  | Polish brass door handles |
|  | Overnight assistance – light cleaning |  | Deficiency lists |  | Stock employee change rooms |
|  |  |  |  |  |  |
| **Human Resources** | |  |  |  |  |
|  | Surveys |  | Photocopy and build Orientation Binders |  | Build Hiring Packages |
|  | Labels for birthday cards |  | Update Material Safety Data Sheets Binder |  | Assist with Communication boards (recruitment and benefits) |
|  |  |  |  |  |  |
| **Golf Course** | |  |  |  |  |
|  | Mail outs for specific events |  | Gift certificate tracking and filing |  | Make up bag tags for groups |
|  | Stuff brochures |  | Inventory of scorecards and pocket pros |  | Marshalling – requires additional training |
|  |  |  |  |  |  |
| **Front Office** | |  |  |  |  |
|  | Re-program telephones |  | Assist Royal Service agents, if there is front-of-house experience |  | File keys |
|  | General filing for Front Office & Reservations |  | Combine guest history accounts |  | Put stickers on tour key envelopes |

# E1. Sample Letter to Employee

Date

Dear Employee's Name,

We are concerned to hear of your recent injury. We wish to assist you in your recovery and have you return to your regular duties when appropriate.

We have provided you with the following information package that includes,

1. **Letter to Physician:** This form explains the light duty program to the physician and authorizes the physician to disclose information pertaining to this injury.
2. **Physician; Fit for Duty:** Details what the employee is physically fit to do during recovery.
3. **Other:**

Kindly forward this package to your physician and ask him/her to return the completed forms to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as requested in the attached documentation. Please be assured that all information provided will be kept confidential. If your physician has any questions regarding our program or related matters, we have provided the following contact numbers. Calls should be directed to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at phone number (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_.

After you have seen your physician, please contact your supervisor, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, at phone number (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ to let us know your condition. If you are capable of performing light or modified duty, you will be expected to report to work.

If you have any questions or concerns, do not hesitate to call. With your participation and cooperation we may work together toward your return to your regular duties.

Sincerely,

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

Supervisor

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

Phone Number

# E2. Sample Letter to Physician

To the Attending Physician,

Modified work programs assist in the rehabilitation of injured workers. Stay at Work and Return to Work programs for employees with work-related injuries enable companies to reduce the cost of injury and illness. The employee suffers no loss in remuneration and is assigned productive work, which takes into consideration any physical restrictions, identified by you, the medical practitioner. The modified work may consist of modifying the employee’s existing job by removing those tasks the employee is currently unable to do or providing transitional/part-time work until the employee is able to return to full time duty; by providing an alternate productive job; by providing a training opportunity; or by a combination of the above. It is a mutually beneficial situation for both the company and the employee. Thank you for your valuable time and cooperation. If there are any questions in regard to this program, please contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

In order that we, the employer, may help in rehabilitation following this injury, we would like you to be aware that we may be able to offer the employee, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Stay at Work light duties subject to your instructions. This is done to enable the injured employee to remain on the job. **This does not in any way negatively affect the employee’s WCB claim.**

As appropriate, the injured employee or the Physician must return the accompanying form to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Please Fax to:** (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address:

|  |
| --- |
|  |
|  |
|  |
|  |

# E3. Sample Physician/Physical Demands Letter 2

I authorize Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release medical information to my employer, but only that which is related to the “Nature of Injury” as agreed to by me.

|  |  |
| --- | --- |
| Nature of Injury: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name: |  | Employee Number: |  |
| Employee Signature: |  | Date: |  |

**Physicians, please complete the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| Is the employee able to return to work on modified work/modified duty assignment: | | Yes | No |
| **Please circle restrictions:** | |  |  |
| Standing | Lifting/Carrying | Climbing | Repetitive Motion |
| Walk/flat | Lifting < 25lbs | Driving | Keyboarding |
| Walk/uneven | Lifting <50lbs | Heights | Dust/wet |
| **Specific restrictions/comments:** | |  |  |
|  | | | |
|  | | | |
| **Duration of restrictions:** | | 1 2 3 4 Shifts | 1 2 3 4 5+ Weeks |
| **Return to work effective date:** | |  | |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Physician’s name (print) |  | Address |
|  |  |  |
| Signature of attending Physician | | Phone |

# E4. Sample Physician Letter 3

Dear Doctor:

We at Company Name/Organization, in conjunction with the Workers' Compensation Board, are committed to a Modified Work Program for employees who are recovering from illness/injury. Our aim is to provide Stay at Work duties to help rehabilitate the employee to his/her pre-injury occupation in the shortest possible time.

The following are an example of the light duty jobs that we have available:

|  |  |
| --- | --- |
| **Job Description** | **Physical Requirements** |
| Stock Count | Walking and writing |
| Office Assistant | Sitting and writing |
| Order Dispatch and Retrieval | Walking |
| Remote Control Crane Operation | Walking and operation of lever controls |
| Cab Crane Operation | Operation of lever controls |
| General Plant Clean-up | Operation of sweeping machine, light lifting, light sweeping |

In order to accomplish this program effectively, we would ask you to complete the attached Work Capacity Form so that we can give the employee modified work within these restrictions. We require reassessment every two weeks.

Please invoice Company Name/Organization for costs related to completing this form. We will pay as per the BCMA fee code.

Please note that WCB Physician’s First Report and Physician’s Progress Report forms also inquire if the patient is capable of modified duties.

Thank you in advance for your cooperation in assisting us to rehabilitate our employees.

Yours truly,

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Company Name/Organization |  | Company Name/Organization |
|  |  |  |
| Name, General Manager | | Name, Supervisor |

# E5. Sample Physician Fit for Duty

|  |  |  |
| --- | --- | --- |
| **Employee Name** | |  |
| Sickness | | Non-Occupational Injury |
| Work Related Injury | | Pre-existing Condition |
| Date of Visit      /     / | | Next Visit      /     / |
| Nature of injury: |  | | |

If modified duty is required, please complete the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Lifting from waist | (weight/frequency) | Sitting | (duration/frequency) |
| Lifting from shoulder | (weight/frequency) | Walking | (distance/frequency) |
| Prolonged standing | (duration/frequency) | Climbing stairs | (distance/frequency) |
| Work in damp areas | (duration/frequency) | Ladders | (number/frequency) |
| Work in cold areas | (duration/frequency) | Work at heights |  |
| Work in hot areas | (duration/frequency) | Bending |  |
| Work outdoors | (duration/frequency) | Operate/repair equipment |  |
| Repetition hand/arm | (duration/frequency) | Typing | (typing) |
| Other/comment: |  |  |  |
| Employee may commence Stay at Work duties on      /     /      (date)  Employee may return to modified duties on      /     /      (date) | | | |
| Employee may resume regular duties on      /     /      (date) | | | |
| Temporary restricted hours or gradually increasing hours is available. Please indicate any restrictions of this type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. | | | |

|  |  |  |
| --- | --- | --- |
| Name of Medical Authority |  | Telephone |
| Signature |  | Date |

# F1. Sample Light or Modified Work Offer

Employee Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In keeping with our commitment to provide suitable employment for workers injured in the course of their employment, we are offering you the following work:

Job task(s) or Position:

Specific duties (details):

Physical requirements:

Hours of work per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of days per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Finish date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Project: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your progress will be monitored and the length of this placement will be modified if required based on consultation with your physician, supervisor and the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If you have any concerns, questions or difficulties with the work you have been assigned, please discuss it with your supervisor immediately. Remember that you are only to do the tasks that are allowed within the limits of your physical ability. You are also asked to meet with your supervisor once per week to review your progress.

Offer accepted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Offer rejected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If rejected, provide reason:

# G1. Sample Stay at Work or Return-to-Work Plan/Offer

|  |  |  |  |
| --- | --- | --- | --- |
| Employee: | Job Title: | Supervisor: | Claim #: |
| Home Phone Number: | RTW Start Date: | Anticipated Length of RTW Program: | Doctor:  Phone: |
| **WEEK 1** | **WEEK 2** | **WEEK 3** | **WEEK 4** |
| Hours:        hours/day        days/week | Hours:        hours/day        days/week | Hours:        hours/day        days/week | Hours:        hours/day        days/week |
| Start time: | Start time: | Start time: | Start time: |
| **Goals:** *(duties, amount, weight, frequency, duration, etc.)* | **Goals:** *(duties, amount, weight, frequency, duration, etc.)* | **Goals:** *(duties, amount, weight, frequency, duration, etc.)* | **Goals:** *(duties, amount, weight, frequency, duration, etc.)* |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Comments: | | | |
|  | | | |
| Date: |  | Employee Signature: |  |
| Date: |  | Management Signature: |  |

# G2. Sample Stay at Work or Return-to-Work Plan/Offer

|  |  |
| --- | --- |
| Employee Name: | Department: |
| Supervisor: | Regular Job Title: |
|  | |
| Physical Capacities/Limitations (per physician) | |
|  | |
|  | |
| Date Limitations Began: | Next Review Date: |
|  | |
| **Plan Specifications** | |
| Start Date: | End Date: |
| Describe job and/or specific tasks: | |
|  | |
|  | |
|  | |
| Describe hours/day and days/week, including progression schedule: | |
|  | |
|  | |
| Special considerations: | |
|  | |
|  | |
|  | |
| This Stay at Work or Return to Work Plan has been reviewed and discussed with me to clarify any questions I may have. I have been provided with a copy of this plan. Any difficulties experienced while performing transitional work will be reported to the Return to Work team. | |
| Employee Signature | Date |
| Supervisor Signature | Date |
|  | |
| I have reviewed and discussed this Stay at Work or Return to Work Plan with the employee. In addition, I have provided a copy of the plan to the employee. | |
| Return to Work Team Member | Date |
| Return to Work Team Member | Date |

# H1. Sample Transitional Work Plan

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Employee’s Surname** | **First Name** |  | | **Date of Injury/Illness** (mm/dd/yyyy) | **Unit** |
| **Employee’s Job Title** | **RTW Coordinator** | | **Phone**  (     )      - | | **Today’s Date** |

|  |  |
| --- | --- |
| **Supervisor:** | **Department:** |
| **Describe Job and/or Specific Tasks:** | |
| **Describe Hours per Day and Days per Week, Including Progression Schedule:**    **Anticipated Duration:** | |
| **Special Consideration (i.e. special equipment, etc.):** | |
| **Date:      /     /** (mm/dd/yyyy)  **Supervisor Signature**  **Date:      /     /** (mm/dd/yyyy)  **Employee’s Signature**  **Date:      /     /** (mm/dd/yyyy)  **Physician’s Signature** | |

# H2. Sample Short Term Work Form

**Doctor-approved Short-term Alternate Duty Program**

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Name:** |  | **Date:** |  |

Company name is a company dedicated to minimizing the human and financial cost of injury and disability by developing an individualized, safe and timely process for an employee’s return to work.

We offer upon medical opinion suitable alternate work for work- and non-work-related incidents.

Please have your doctor fill out the attached forms and return them immediately to your supervisor or bring them into the office. Please discuss the alternate job list with your doctor and identify any areas that require further modification.

The following individuals are available to answer any questions you may have concerning this process:

**Management representatives are:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Manager** |  | **Phone** |  |
| **Supervisor** |  | **Phone** |  |

# Note to Physician

Physician:

To assist us in facilitating a safe and timely return to work for our employee, your assistance in completing the attached form would be greatly appreciated. Please return the completed form to:

|  |  |
| --- | --- |
| **Contact:** |  |
| **Company:** |  |
| **Address:** |  |
| **Phone:** |  |
| **Cellular:** |  |

# Physician’s Assessment of Employee’s Return to Work

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Worker’s Name:** | | |  | | | | | | | | **Date of Injury/Illness:** | | | | | | | | | |  | | | | | |
|  | | |  | | | | | | | |  | | | | | | | | | |  | | | | | |
|  | It is recommended for the employee to access additional treatment | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | Physiotherapy | | |  | | Chiropractic |  | | Massage Therapy | | | | | | |  | Athletic Therapy | | | | | |  | Other |  | | | |
|  | The employee can return to work with consideration that symptoms may limit certain work tasks. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | The employee can return to work with the following restrictions: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Walking** | | | |  | | Restricted to less than 1 hour | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | Restricted, other – please specify: | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | **As Tolerated** | | | | | | | | | | | | | | | | | | | | | | |
| **Standing** | | | |  | | Restricted to less than 1 hour | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | Restricted, other – please specify: | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | **As Tolerated** | | | | | | | | | | | | | | | | | | | | | | |
| **Sitting** | | | |  | | Restricted to less than 1 hour | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | Restricted, other – please specify: | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | **As Tolerated** | | | | | | | | | | | | | | | | | | | | | | |
| **Bending and Twisting** | | | |  | | No bending or twisting | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | Restricted, other – please specify: | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | **As Tolerated** | | | | | | | | | | | | | | | | | | | | | | |
| **Lifting floor to waist** | | | |  | | No lifting | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | No lifting over 20 lbs. | | |  | | | | No lifting over 40 lbs. | | | | | |  | | | No lifting over 60 lbs. | | | | | | |
|  | | | |  | | **As Tolerated** | | | | | | | | | | | | | | | | | | | | | | |
| **Lifting waist to head** | | | |  | | No lifting | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | No lifting over 20 lbs. | | |  | | | | | No lifting over 40 lbs. | | | | | |  | | | No lifting over 60 lbs. | | | | | |
|  | | | |  | | **As Tolerated** | | | | | | | | | | | | | | | | | | | | | | |
| **Carrying** | | | |  | | No carrying | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | No carrying over 20 lbs. | | | | | |  | | | No carrying over 40 lbs. | | | | | | | | | | | | |
|  | | | |  | | **As Tolerated** | | | | | | | | | | | | | | | | | | | | | | |
| **Gripping / Pulling** | | | |  | | No gripping/pulling | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | No gripping/pulling > 2 hrs/day | | | | | |  | | | | No gripping/pulling > 4 hrs/day | | | | | | | | | | | | |
|  | | | |  | | **As Tolerated** | | | | | | | | | | | | | | | | | | | | | | |
| **Climbing Stairs / Equipment** | | | |  | | Restricted, please specify: | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | **As Tolerated** | | | | | | | | | | | | | | | | | | | | | | |
| **Equipment Operation** | | | |  | | Prescription medication prohibits driving | | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | No night time driving / equipment operation | | | | | | | | | | | | | | | | | | | | | | |
| **Other Comments / Recommendations** (Please specify, i.e. medication side effects.) | | | |  | |  | | | | | | | | | | | | | | | | | | | | | | |

The following is a list of jobs that may be included in a person’s Return to Work program, understanding that these can be altered further based on medical opinion on the needs of the injured worker to accomplish a successful Return to Work accommodation:



The employee may be an extra person while on the program. Depending on the employee’s qualifications, other tasks may be incorporated into the program. The program could consist of short periods of time on a variety of tasks that will aim at getting the employee back to their regular job.

# H3 – Sample Functional Abilities Assessment Form

**A Worker’s Information (completed by RTW Coordinator or employee)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Employee’s Surname | First Name | | Occupational  Non-Occupational | Date of Injury / Illness | | Unit |
| Employee’s Job Title | | RTW Coordinator Name:  Tel. No. (     )      -      Fax. No. (     )      - | | | Today's Date | |

It is the intention to assist our employees to safely return to their regular duties as soon as medically practical. In doing so, we are able to offer the employee modified duties as a means to transition to their regular duties. The following will assist in this process.

**B Assessment (Part B, C and D to be completed by attending physician)**

|  |
| --- |
| Due to injury or illness this employee has: **Normal functional Abilities** (*Fit for Regular Duties*) **Reduced Functional Abilities**  (No additional information needed. Please sign section E) (Please complete Section C , D & sign section E) |

**C Functional Abilities: *(If unable to test, please estimate)***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Step 1** Please circle the appropriate letter(s) & Body area(s) to indicate the affected area(s) | **Step 2** Please indicate Reduced abilities | | **Step 3** Please indicate extent of abilities | | | | | **Comments** | |
| figure  A Systemic or Non-Physical  B Head *(incl. Vision, hearing, speech)*  C Neck  D Upper back, chest, upper abdomen  E Lower Back  F Lower abdomen  G Shoulder or upper arm  H Elbow or lower arm  I Wrist or hand  J Hip or upper leg  K Knee or lower leg  L Ankle or foot  M Respiratory/Aerobic | Walk | | Maximum Duration (*hours*): 1 2 4 5+ Other  Short distances only No walking | | | | |  | |
| Stand | | Maximum Duration (*hours)*: 1 2 4 5+ Other | | | | |
| Sit | | Maximum Duration (*hours*): 1 2 4 5+ Other | | | | |
| Lift/Carry  Floor – waist  Waist – shoulder  Above shoulder | | Occasionally | Weight (*kg*)  21 16 9 | | | < 9kg - Specify |
|  | 21 16 9 | | |  |
|  | 21 16 9 | | |  |
| Bend/Twist  Neck  Back | | Occasionally | Not at all | | | Specify |
|  |  | | |  |
| Push/pull  Moderate load  Light load | | Occasionally | Not at all | | | Specify |
|  |  | | |  |
| Climb  Flight of stairs  Few steps | | Occasionally | Not at all | | | Specify |
|  |  | | |  |
| Reach  Above shoulder  Below shoulder | | Occasionally | Not at all | | | Specify |
|  |  | | |  |
| Use Hands For:  Writing  Typing  Fine manipulation  Grasping | | Occasionally  L R  L R  L R  L R | Not at all  L R  L R  L R  L R | | | Specify |
| Sensory  Specify: | | To See | To Hear | | | To Speak | To Maintain Balance | |
| Operate Equipment | | Specify: | | | | | | |
| Hours of Work | | Specify: Normal hours or graduated RTW? | | | | | | |
| Prescription medication | | Will it affect ability to work/drive: | | | | | | |
| **Other Comments/Instructions** (NO DIAGNOSIS OR TREATMENT): | | | | | | | | | |
|  | | | | | | | | | |
| **D** Normal functional abilities may resume in: 1-3 days 4-7 days 8-14 days Specify: | | | | | | | | | |
| \*Other: Employee is not medically fit for regular duties, will require periodic reassessments for effective rehabilitation. | | | | | Scheduled reassessment date for: | | | | |
|  | | | | | | | | | |
| **This authorizes my attending physician to provide the information requested above to COMPANY NAME** | | | | | | Employee's Signature: | | | Date: |
|  | | | | | | | | | |
| **E** Physician's name & address: | | Physician's Signature: | | | | | | | |
| Physician's Telephone No: | | | | | | | |
| Date: | | | | | | | |