

Condon School District 25J

Code: **GBEA-AR**
Adopted: 4/12/94
Readopted: 11/9/05; 11/20/08

Return to Work Procedure

It is the policy of the district to provide modified work to employees who have been injured on the job or otherwise are temporarily unable to perform their jobs. Early return to work is a benefit that has been shown to improve recovery and ensures that the employee does not suffer further from loss of wages or work.

The superintendent will determine whether a modified work assignment can be provided which will be consistent with the treating physician's work release and the needs of the district. Reasonable effort will be made to accommodate the needs of the employee by modifying his/her present work setting, however, work availability may make it necessary to transfer employees from one building/site to another at the discretion of the superintendent. The superintendent will be the liaison with the insurance company and medical provider.

The superintendent will assist the employee with filling out the 801 Form and arrange for first aid or transportation to medical care as needed. While the employee is unable to work, the supervisor will contact the employee by phone once a week to keep informed of the employee's work status and to keep the employee informed of scheduling changes.

The deputy clerk will assist the employee with filling out the 801 Form and make sure the employee gets a copy of the Notice to Doctor Form to take to the doctor and be the insurance contact for payroll information.

It is the employee's responsibility to report all injuries immediately and to provide the manager/personnel with accurate and timely information regarding the injury, physical restrictions as identified by their physician, and changes in their medical condition. Upon return to modified work, the employee will not work beyond the restrictions identified by their physician.

Definitions

Modified Work

Redesigning job duties to match injured employee's physical and mental restrictions as identified by the treating physician. Examples of job modifications include: new work hours (flextime, part-time); new duties assigned and/or old duties changed; new equipment acquired at workstation; additional training.

Time Loss

Wage replacement benefit provided by workers compensation insurance. Worker is eligible for this benefit after three consecutive days off work authorized by a treating physician.

Job Analysis

Written description of the physical demands of a job.

801 Form

State of Oregon Worker's and Employer's Report of Occupational Injury or Disease.

Return to Work Responsibilities/Procedure

Superintendent:

1. Assists employee with filling out forms.
2. Maintains weekly phone contact with injured employee until employee is able to return to regular or modified work.

Deputy clerk:

1. Participates in accident investigation.
2. Sends job analysis for regular or modified work to treating physician.
3. When physician releases employee for modified work, will prepare written job offer letter (offer of available employment) and call employee in to discuss the job.

See next page for Return to Work Responsibilities/Procedure

Return to Work Responsibilities/Procedure Employee

- 1. Reports injury immediately to direct supervisor. If first aid only is required, fills out incident report. 802 Form not required.
- 2. If medical treatment required, completes 801 Form and picks up Restriction Form from bookkeeper.
- 3. It is preferred that the employee see a physician the same day as the injury, if possible. Immediate and urgent care clinics on same day appointments. Serious injuries should be seen in the emergency room.
- 4. Has physician fill out physical restrictions form and returns it with medical diagnosis to manager, in person, on same date as appointment.
- 5. Must provide written update to manager of physical restrictions or inability to work, in person, after each additional doctor's appointment.
- 6. While unable to work, contacts manager each Monday, by phone, to keep manager informed of work status.
- 7. Upon returning to modified work, employee agrees not to exceed restrictions identified by physician.
- 8. Employees participating in modified work are expected to schedule doctor and therapy appointments outside of work hours to avoid loss of earning power. If this is not possible, appointments should be scheduled at the end of the shift.

I have read and understand these procedures and responsibilities. Failure to follow these procedures may affect my right to re-employment, reinstatement or possible future vocational assistance following disability.

Staff Signature

Date

Type on your company any letterhead

Notice of Available Employment

Date _____ Name _____

Address _____

City, State, Zip _____

Claim No _____

Date of Injury _____

Dear _____,

Your attending physician, Dr. _____ has released you from modified work. We have located a position for you which your physician feels you will be able to perform successfully.

The job is: _____ . See attached job analysis with physician's approval.
You will receive \$ _____ per hour/week/month. SAIF Corporation will prorate your worker's compensation benefits if this salary is less than your regular wage.

We ask that you report for work:

Date: _____ Hours per day/week: _____

Time: _____ Duration of job: _____

Report to: _____ Phone: _____

Location _____

If you receive this letter after the report to work date, you have 24 hours to contact:

Failure to report to work could affect time-loss compensation, could mean loss of your reemployment and reinstatement rights, and could affect your vocational eligibility.

We are looking forward to seeing you and wish you a speedy recovery.

(Employer's Signature)

(Date)

I have read and understand the above information. I accept this job as offered Yes No

(Employer's Signature)

(Date)

(Date)

(Name of Employee)

(Address)

(City, State, Zip)

SAIF Claim Number

Social Security Number

Date of Injury

Dear _____ :

Your physician , Dr. _____ , released you for modified work on _____ .

As a result, you were offered a modified temporary job. This job was: _____ .

You received \$ _____ per (hour/week/month) while working the modified job. SAIF Corporation pro-rated your worker's compensation benefits if less than regular wage.

You were asked to report for work on:

Date: _____ Hours per day/week: _____

Time: _____ (a.m./p.m.) Duration of job: _____

Report to: _____ Phone Number _____

Location: _____

You did not sign a modified work assignment letter at the beginning of the modified job. You were however, aware that (employer's) return to work policy offers modified duty to on-the-job injured employees. We ask that you review the above information and complete the information at the bottom of this page.

Sincerely,

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(Name, Title)

(Department)

(Telephone Number)

I have read, understand and verify the above information.

Employee Signature

Date

PLEASE RETURN THIS LETTER TO OUR OFFICE

SAIF CORPORATION
Physical Status Update

Name of worker _____ Claim number _____ Please
complete the following:

Weightlifting Capabilities

- 10 pound maximum, 5 pounds frequently
- 20 pound maximum, 10 pounds frequently
- 50 pound maximum, 25 pounds frequently
- Over 50 pound maximum, up to 50 pounds frequently

Total hours (with breaks) patient can sit. stand. walk in an 8-hour day

- | | | | | | | | | | | |
|----------|---|-----|---|---|---|---|---|---|---|---|
| 1. Sit | 0 | 1/2 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 2. Stand | 0 | 1/2 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 3. Walk | 0 | 1/2 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

Activity	None	Occasional (up to 33% of time)	Frequent (34%-66% of time)
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- Stoop, twist, bend
- Squat, crawl, kneel
- Push, pull
- Climb
- Reach above shoulder

_____ No repetitive use of	_____ R	_____ L	Wrist/hand
_____ No use of	_____ R	_____ L	Wrist/hand
Dominant hand	_____ R	_____ L	

Can use foot pedals Yes No

Given the above limitations: How many hours per day can this patient work? _____
How many hours per week can this patient work? _____

Comments: _____

Physician name: _____ Date: _____

Physician Signature _____

NOTICE TO TREATING PHYSICIAN
(To be prepared by injured worker when reporting for treatment)

_____ has reported he/she was injured on _____.
Worker _____ Date _____

Send the (827) "Doctor's First Report of Work Injury" immediately to:
SAIF CORPORATION
400 High Street, SE
Salem, Oregon 97312

Date: _____ Supervisor's Signature: _____

RETURN TO WORK

(To be completed by physician after examining employee)

Medical office or clinic name: _____

Treatment date: _____ Time of arrival: _____ Time of departure: _____

Is employee able to return to regular work duties? _____ Yes _____ No

If no, what are employee's limitations? _____

Projected date of return to regular or light duty work: _____

Is another appointment needed? _____ Date: _____ Time: _____

Physician's Signature

Date

Upon completion of this form, give to employee to return to employer