Neah-Kah-Nie
School District 56

Code: **GCBDB/GDBDB-AR**
Adopted: 11/12/01
Readopted: 2/11/08; 5/11/15
Orig. Code(s): GCBDB/GDBDB-AR

Early Return to Work

1. Upon notification of a work-related injury, the supervisor reviews the employee's signed "Responsibilities Regarding On-The-Job Injuries/Accidents" form with the employee and may assist with the completion of an 801 form by the employee. The supervisor submits the completed 801 form to the personnel department who will then notify the workers compensation carrier.

2. The personnel department contacts the employee and his/her physician to remind all parties of the company's light/modified duty program and the need for the completed work release/physical capacities evaluation. The employee shall report back to the supervisor with a completed work release/physical capacities form after every physician visit. The supervisor will forward the work release/physical capacities form to the personnel department who will then send a copy to the workers compensation carrier.

3. The supervisor reviews the work release/physical capacities form and identifies whether light/modified duty work is available within the outlined physician's restrictions. Consideration will be given to flexible hours, reduced lifting, use of a stool to eliminate standing, etc.

4. Light/Modified duty is considered to be any work within the employee's physical capacities, as outlined in the most recent work release/physical capacities form. All light/modified duty positions must be approved by the personnel department and availability is subject to the business needs of the district, which are determined at its sole discretion.

5. If the employee does not provide the work release/physical capacities form, the supervisor will notify the personnel department. The personnel department may send the physician a written request for this information.

6. Once the work release/physical capacities information has been obtained and a light/modified job identified, the supervisor completes a job analysis of the light/modified duty position and submits it to the personnel department for approval. If approved, the personnel department will submit it to the attending physician for review. If not approved by the personnel department, the supervisor will be notified of the decision.

7. Upon receipt of the physician's signed and dated approval of the job analysis, the personnel department will provide a written job offer of this position to the employee via certified mail and regular mail or in person. The offer will include: the starting date and time; wage and hours; to whom and the location where the worker is to report; a copy of the work release or signed job analysis; and a description of the job duties. A copy of the job offer letter, approved job analysis and the most recent work release/physical capacities form will be sent to the supervisor.

8. Before the employee starts the light/modified job, the supervisor will meet with the employee and carefully review the job, outlining all job duties and the employee's limitations, as set forth by the treating physician. The supervisor should emphasize the need for the employee to perform the job duties within the limitations prescribed by the physician. The supervisor will then obtain the employee's signature on the job offer letter.

9. Should the employee refuse to accept the light/modified job offer, the supervisor will report this to the personnel department which will then notify the workers compensation carrier.

10. The supervisor sends the signed job offer letter to the personnel department who will forward a copy of the signed job offer letter, physician approved job analysis and most recent work release/physical capacities form to the workers compensation carrier.

11. The employee's light/modified duty job will end when the employee is either released to regular employment, the workers' compensation claim is closed, the employee has returned to other work which is not considered part of the employer's light duty/modified duty program, or at such time as the district determines that business needs are not being served by the light/modified duty work assignment.

12. The supervisor is responsible for monitoring the employee's participation in the light/modified duty job and keeping track of the hours worked. This information will be submitted to the personnel department with other time records. Any problems noted with the employee's participation in the light/modified duty job should be reported immediately to the personnel department, who will then discuss the issue with the employee and physician and make any needed modifications.

13. The employee is responsible for providing the supervisor written notice of the physician's recommendations of new restrictions and/or changes to the previously approved light/modified duty job. The supervisor will provide recommendations of the necessary modifications to the personnel department.

14. Any changes to the originally approved and accepted light/modified duty job must be approved by the personnel department. The personnel department may send a second letter to the employee's attending physician to request approval of any recommended changes.

EMPLOYEE RESPONSIBILITIES REGARDING ON-THE-JOB INJURIES/ACCIDENTS

1. Report all accidents/incidents, no matter how slight, immediately to your supervisor. Reporting on your next work shift is not an acceptable practice.

2. If you need to see a doctor, complete the "worker" portion of a Report of Occupational Injury or Disease (Form 801). Your supervisor will provide assistance in completing this form if you need help and may provide you with a light/modified duty packet if your injury prevents you from returning to work.

3. Bring the light/modified duty packet to your physician visit. Should your physician authorize time loss, there is at least a three-day waiting period before time-loss benefits will begin. To avoid loss of wages, inform your doctor that light/modified duty is available and have your physician complete the Work Release/Physical Capacities form.

4. Report your physician's findings immediately (within 24 hours) to your supervisor. The Work Release/Physical Capacities form should be completed at each physician visit and returned to your supervisor.

5. You must report to your next scheduled shift once the doctor releases you to work (part-time, light, modified or regular).

I have read the above responsibility sheet. I have been given an opportunity to ask questions about my responsibilities. I agree to follow all of these responsibilities and understand that failure to do so may adversely affect my workers' compensation benefits. I have been given a copy of this document.

_____ _____

Employee Signature Date

cc: File

Date

Dr.
Street
City, State Zip

Re: *Employee Name* Claim Number:

Dear Doctor:

Thank you for your prompt treatment of our employee. For your information, we do attempt to provide light/modified duty work for all our occupationally injured employees. The tasks provided range from sedentary clerical tasks to a modification of the employee's regular duties.

Enclosed for your review is a job analysis for a light/modified duty position currently available. Upon receipt of your approval, the employee will be offered the position.

Thank you for your assistance.

Sincerely,

Enclosures

Date

Dr.
Street
City, State Zip

Re: *Employee Name* Claim Number:

Dear Doctor:

Thank you for your prompt treatment of our employee. For your information, we do attempt to provide light/modified duty work for all our occupationally injured employees. The tasks provided range from sedentary clerical tasks to a modification of the employee's regular duties.

Please complete the enclosed Work Release/Physical Capacities form. A light/modified duty job analysis will be submitted for your review prior to any job offer.

Thank you for your assistance.

Sincerely,

Enclosures

WORK RELEASE/PHYSICAL CAPACITIES

Re: *Employee Name* Claim Number:
Employer: Date of Injury:

The above worker may return to:

Regular work on: _____

or

Modified work on: _____

or

Is not released, anticipated release date:_____

If modified work, please complete entire form

Is worker capable of full time? ____Yes____No
If unable to work full time, specify hours per day_____

Please indicate which level of modified work the worker is capable of performing:

_____ **Sedentary work:** Lifting 10 pounds maximum. Includes occasionally lifting and/or carrying small objects. Involves sitting; a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking, standing is required only occasionally and all other sedentary criteria are met.

_____ **Light work:** Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds; or requires walking or standing to a significant degree; or requires sitting most of the time but entails 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 15-20 pounds; or requires walking or standing to a significant degree; or requires sitting most of the time but entails pushing of arm and/or leg controls.

_____ **Medium work:** Lifting 50 pounds maximum with frequent lifting and carrying of objects.

_____ **Heavy work:** Lifting 100 pounds maximum with frequent lifting and carrying of objects weighing up to 50 pounds.

Other specific restrictions: (i.e. climbing, kneeling, bending, stooping, repetitive motion, reaching, grasping, overhead work, twisting, dry environment, etc.)

The modified work restrictions are:

_____Permanent_____ Temporary; expected to last_____weeks.

Next appointment date:_____

_____ _____
Physician's signature Date

cc: The district's workers compensation carrier.

Date

Certified Mail, #
Return Receipt Requested

Employee Name
Address
City, State Zip

Re: Claim Number: Date of Injury:

Dear *(Employee Name):*

Your doctor has released you for light/modified duty work. Attached is a copy of the work release. We are offering you a light/modified duty job, as described below. Unless otherwise stated, the duration of this job is unknown.

Job Title: _____ Starting Time: _____
Starting Date: _____ Hours per Day: _____
Wage: _____ Hours per Week: _____
Where to Report: _____ Report to Whom: _____

Description of Job Duties:
_____
_____
_____

While on light/modified duty, your workers' compensation benefits may be offset by your wages.

If you choose not to accept this job offer or do not report to work as specified, your workers' compensation benefits may be adversely affected.

Sincerely,

I read the above and accept the job as offered _____Yes _____No

_____ _____ _____ _____
Employee's signature Date Witness' signature Date

cc: The district's workers compensation carrier.
Employee/Regular mail
Employee Attorney

enc: Physician approved job analysis and/or
copy of light duty release

Date

Dr.
Street
City, State Zip

Dear Doctor:

Our employee _____ has been on light/modified work as a _____since _____. We would like to increase _____ *(the worker's name)* duties in an effort to return him/her to regular work.

The restrictions you placed were:

Lifting limit: _____ Increase to: _____

Standing limit: _____ Increase to: _____

Other: _____ Increase to: _____

Please indicate in the space provided, any increases, and the period of time for which these increases will be in effect.

_____(the worker's name) regular job is _____ (see attached job description). Please complete the information below and return this form to our office..

Thank you for assistance.

Anticipated release to regular work: _____

Sincerely,

_____ _____
Doctor's signature Date

cc: Employee
The district's workers compensation carrier.
Worker Attorney

Employee Name			
Employer Name		Claim Number	
Evaluator		Employer Contact	
Job Title	Temp / Regular (circle one)	Date of Injury	Date

Specific Task Requirements

1.
2.
3.

Physical Requirements - Please check the box for each of the tasks the worker will perform.

	Total Hours in 8-hr Day			
Body Movements	**0-1**	**1-3**	**3-6**	**6-8**
Bend at Waist				
Twist upper body				
Kneel				
Walk - Uneven surface				
Climb				
Reach above shoulders				
Repetitive use of hands				
Handling/Grasping				
Fingering/Feeling				
Operate Foot Controls				
Endurance				
Sit				
Stand				
Walk				

		Total Hours in 8-hr Day				
Physical		**0-1**	**1-3**	**3-6**	**6-8**	
Lift	1-10 lbs					
	11-19 lbs					
	20-49 lbs					
	over 50					
Carry	1-10 lbs					
	11-19 lbs					
	20-49 lbs					
	over 50					
Push	1-10 lbs					On wheels
	1-19 lbs					
	20-49 lbs					
	over 50					
Pull	1-10 lbs					
	11-19 lbs					
	20-49 lbs					
	over 50					

Environment - Include if job is performed indoors, and if temperature extremes exist:

Hazards - (Include noise, light, fumes, dust, ventilation, floor surface, etc.):

Equipment/Tools Used - (Please indicate if hand or machine driven):

Products/Materials - (Product produced and raw materials used):

Comments:

_____ may be released for the above duties for _____ hours
(Employee Name)
per day on _____.
(Date)

_____ _____
Physician Signature Date