Riverdale School District 51J

Code: **GCBDB/GDBDB-AR**
Adopted: 8/16/04
Readopted: 6/12/06
Orig. Code(s): GCBDB/GDBDB-AR

Early Return to Work

Objectives:

The district has developed a return to work policy. Its purpose is to return workers to employment at the earliest date following any injury or illness. We desire to speed recovery from injury or illness and reduce insurance costs. This policy applies to all workers and will be followed whenever appropriate.

The district defines "transitional" work as temporary modified work assignments within the worker's physical abilities, knowledge and skills. Where feasible, transitional positions will be made available to injured employees in order to minimize or eliminate time loss.

The physical requirements of transitional/temporary work will be provided to the attending physician. Transitional/Temporary positions are then developed with consideration of the worker's physical abilities, the business needs of the district and the availability of transitional work.

In case of an on-the-job accident

If you have a work-related injury and are missing time from work, contact the district office or SAIF Corporation for details regarding time-loss.

Transitional temporary work assignment

The district will determine appropriate work hours, shifts, duration and locations of all work assignments. The district reserves the right to determine the availability, appropriateness and continuation of all transitional assignments and job offers.

Communication

It is the responsibility of the worker and/or supervisor to immediately notify the district office of any changes concerning a transitional/temporary work assignment. The district office will then communicate with the insurance carrier and attending physician as applicable.

Employee responsibilities

1. Accident reporting:

   a. An accident is any unplanned event that disrupts normal work activities and may or may not result in injury or property damage. All work-related accidents, injuries and near misses must be reported immediately to the district office.

b. If an accident occurs, but does not require professional medical treatment, the supervisor should immediately be informed, so that an Investigation Report can be completed. If first-aid treatment is needed, it should be sought on-site.

c. If an accident occurs which requires professional medical treatment, the worker should follow the emergency response plan. The worker must fill out a workers' compensation form 801 form as soon as possible.

2. Worker's physical condition:

   a. If professional medical treatment is sought, the worker should inform the attending physician the district has a return-to-work program with light duty/modified assignments available.

   b. The worker should obtain a Return-to-Work Information form and completed Job Description form from the district office. This should be provided to the treating physician and should be returned to the district office following the initial medical treatment.

3. Worker return to work:

   a. If the attending physician releases the worker to return to work, as evidenced by completion of a RTW Information Form and Job Description Form, the form(s) must be returned to the district office, within 24 hours for assignment of light duty/modified work. The worker must report for work at the designated time. The worker cannot return to work without a release form the attending physician.

   b. If you return to a transitional/temporary job, you must make sure that you do not go beyond either the duties of the job or your physician's restrictions. If your restrictions change at any time, you must notify your supervisor at once and give your supervisor a copy of the new medical release.

4. Worker unable to return to work:

   a. If the worker is unable to report for any kind of work, the worker must call in at least weekly to report medical status.

   b. While off work, it is the responsibility of the worker to supply the district office with a current telephone number (listed or unlisted) and an address where the worker can be reached.

   c. The worker will notify the district office within 24 hours of all changes in medical condition.

Employer responsibilities

1. Accident reporting:

   a. The supervisor will conduct an accident investigation on all accidents, whether or not an injury occurs.

   b. When an accident occurs which results in injury requiring professional medical treatment, the district office will forward a completed workers' compensation 801 form to the insurance carrier within five calendar days of knowledge of the injury or illness.

   c. Other information will be forwarded as soon as developed including:

      (1) Name of worker's attending physician.

(2) Completed release to work form from attending physician and medical documentation, if appropriate.
(3) Completed transitional/modified or regular job description.
(4) Job offer letter and responses.

d. The supervisor will notify the insurance carrier of any changes in the worker's medical or work status as soon as possible.

2. Medical treatment and temporary/transitional duty physical condition:

   a. A RTW Information Form and a completed Job Description form (if available) will be provided to the worker to take to the attending physician for completion and/or approval.
   b. At the time of first medical treatment the RTW Information Form must be completed and returned to the district office. If one is not, the district office will request one from the attending physician.
   c. If feasible, the district office will accompany the worker to the first visit with the treating physician.
   d. The completed RTW Information Form will be reviewed by the district office. A temporary/transitional Job Description form will be prepared from information obtained from the attending physician for review and approval.

3. Job offer letter:

   a. Upon receipt of a signed temporary/transitional Job Description form from the attending physician, a written Job Offer Letter will be prepared by the employer. It will be mailed by both regular and certified mail to the worker's last known address or presented to the worker.
   b. The letter will note the doctor's approval and will explain: the job duties, report date, wage, hours, report time duration of transitional work assignment, phone number and location of the transitional assignment.
   c. The worker will be asked to sign the bottom of the Job Offer Letter indicating acceptance or refusal of the offered work assignment.
   d. Copies of the Job Description, Work Releases, and Job offer Letters will be forwarded to the insurance carrier.

4. Supervisor:

   a. The supervisor will monitor the worker's performance to ensure the worker does not exceed the worker's physician release.
   b. The supervisor will monitor the worker's recovery progress through regular contact to assess when and how often duties may be changed. The supervisor will assess the district's ability to adjust work assignments upon receipt of changes in physical capacities.

Worker acknowledgment:

1. The return-to-work policy and procedures have been explained to me.

2. I have read and fully understand all procedures and responsibilities.

3. I agree to observe and follow these procedures.

4. I have received a copy of this policy and procedure.

5. I understand failure to follow these procedures may affect my re-employment, reinstatement and vocational assistance rights.

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Worker Signature   Date

____

Superintendent Signature   Date

MANDATORY ACCEPTANCE

Date_______________________________________

Name of Employee _______________________________________
Address _______________________________________
City, State Zip _______________________________________

SAIF Claim No.: ______________________________
DATE of Injury: ______________________________

Dear ________________________:

Your attending physician, Dr. ___________________________, has released you for modified work. We have located a temporary position for you, which your physician feels you will be able to perform successfully. The availability of this position will be periodically re-evaluated.

The job is:_____________________________________ *See attached job description with physician's approval.

You will be receiving $_______________ per (hour/week/month). SAIF Corporation may supplement your wages with workers' compensation benefits.

We ask that you report for work on:

Date:___________________________________ Hours per day/week:___________________________________

Time:___________________________________(a.m./p.m.) Duration of job: ____________________ (__________ shift)

Report to:_____________________________________ Phone:_____________________________________

Location:____
(This location is less than 50 miles from where you were injured or less than 50 miles from where you live.)

If you receive this letter after the start date of this job, the job will begin 24 hours after your receipt of this offer. Immediately upon receipt of this letter, please contact:

____

FAILURE TO REPORT TO WORK COULD AFFECT TIME-LOSS COMPENSATION, VOCATIONAL ELIGIBILITY, AND COULD AFFECT YOUR REINSTATEMENT RIGHTS.
Please see attached Oregon Administrative Rules concerning your rights and obligations under this offer of transitional/temporary employment. These attached rules are fully incorporated into this job offer.
If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reason(s) for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's action(s) to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282.

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

Sincerely,

Name, Title:
Department:
Telephone:

I have read and understand the above information. I accept this job as offered. Yes_____No_____

____
Employee Signature Date

OAR 436-060-0030(5)
The employer or insurer has confirmed the offer of employment in writing to the worker stating:

1. the beginning time, date and place;

2. the duration of the job, if known;

3. the wages;

4. an accurate description of the physical requirements of the job; and

5. that the attending physician has found the job to be within the worker's capabilities and the commute within the worker's physical capacity;

6. the worker's right to refuse the offer of employment without termination of temporary total disability if any of the following conditions apply:

    a. The offer is at a site more than 50 miles from where the worker was injured, unless the work site is less than 50 miles from the worker's residence, or the intent of the employer and worker at the time of hire or as established by the employment pattern prior to the injury was that the job involved multiple or mobile work sites and the worker could be assigned to any such site. Examples of such sites include, but are not limited to logging, trucking, construction workers, and temporary employees;
    b. The offer is not with the employer at injury;
    c. The offer is not at a work site of the employer at injury;
    d. The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or
    e. The offer is not consistent with an existing shift change provision of an applicable union contract; and

7. The following notice, in prominent or bold face type:

"If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reason(s) for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's action(s) to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282."

OPTIONAL ACCEPTANCE LANGUAGE

Date ________________________________

Name of Employee ________________________________
Address________________________________
City, State Zip ________________________________

SAIF Claim No.: ________________________________
DATE of Injury: ________________________________

Dear ____________________:

Your attending physician, Dr. ______________________, has released you for modified work. We have located a temporary position for you which your physician feels you will be able to perform successfully. The availability of this position will be periodically re-evaluated.

The job is:________________________________ *See attached job description with physician's approval.

You will be receiving $______________ per (hour/week/month). SAIF Corporation may supplement your wages with workers' compensation benefits.

We ask that you report for work on:

Date: ____________________________ Hours per day/week: ____________________________

Time:____________________(a.m./p.m.) Duration of job:____________________________
(__________ shift)
Report to:________________________________ Phone: ________________________________

Location:________________________________

If you receive this letter after the start date of this job, the job will begin on the next working day after your receipt of this offer. Immediately upon receipt of this letter, please contact:

____

FAILURE TO REPORT TO WORK WILL NOT AFFECT TIME-LOSS COMPENSATION.

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

Sincerely,

Name, Title:
Department:
Telephone:

(Send by certified and regular mail, or have worker come to office to sign and date letter)

I have read and understand the above information. I accept this job as offered. Yes_____No_____

____
Employee Signature Date