Example of a Customized
Stay at Work/ Return to Work Program
With Supporting Forms

- ✓ Workers Compensation Stay at Work/Return to Work Sample Program
- ✓ Work Capabilities Form
- ✓ Temporary Modified/Alternate Work Assignment Form
- ✓ Supervisor's Responsibilities
- ✓ Supervisor's Report of Accident Investigation
- ✓ Job Hazard Analysis Worksheet

Sample Program for ***ABC Company, Inc.***

Workers Compensation Stay at Work/Return to Work Program

ABC Company, Inc. is implementing a new **Workers Compensation Stay at Work/Return to Work Program** for injured employees as a means of helping them stay at work with practical modifications when necessary.

ABC Company, Inc.'s strong stay at work effort will yield several benefits to our employees and ***ABC Company, Inc.,*** including:

- Acceleration of the injured employee's recovery
- A quicker return to productivity
- Maintenance of earning power for the employee
- Continuity of medically supervised employment
- Maintenance of an experienced work force
- Reduction in claim costs
- Improved employee relations
- Maintenance of an employee's sense of self-worth and productivity

Our first responsibility is the **prevention** of occupational injuries and/or illnesses. Despite our best efforts, however, injuries and illnesses do sometimes occur. It then becomes our responsibility to reduce the impact of the disability on both the employee and the company. ***ABC Company, Inc.*** is committed to providing temporary modified or alternate duties on a case by case basis.

By modified or alternate duties, we mean:

- Appropriate work during the resolution of the injury and to prevent re-injury
- Modification of a job consistent with the injured employee's abilities
- Setting a positive atmosphere and letting employees ease back into their normal routine by adjusting work requirements, encouraging employees to adhere to therapy schedules and explaining the need for modified or alternate work to the employee's co-workers in order to reduce peer resentment
- A meaningful, productive position for both the employee and the organization
- Work assignments that are **temporary** - temporary modified or alternate work assignments will be reviewed every week

A medical provider must authorize modified or alternate work assignments before an employee can return to work. **Temporary modified or alternate work should be limited to no more than thirty consecutive calendar days without a complete reassessment**.

If the injured employee seeks medical treatment with his/her own physician at the time of the initial medical treatment, the treating physician will need to complete the ***ABC Company, Inc.*** Work Capabilities Form and contact the Human Resources Manager. By completing this form, the physician will assign physical work capabilities in accordance with the injury and treatment prescribed. Also, an initial prognosis will be stated that specifies the length of disability or capabilities. If the injured employee is treated by a physician at ***ABC Company, Inc.'s*** medical care provider, a Work Capabilities form will be completed by the attending physician which lists the type of treatment, work status, work restrictions and follow-up plan.

As soon as practicable, the Human Resources Manager and the injured employee's Supervisor will coordinate whatever modifications may be necessary in the employee's regular job or, if necessary, arrange for alternate duties.

Once the injured employee's position is modified, his/her progress will be reviewed weekly by the Supervisor and the Plant Manager, the Production Manager or the General Supervisor until the employee returns to his/her original position.

ABC Company, Inc. Work Capabilities Form

Dear Doctor:
You have an ***ABC Company, Inc.*** employee in your care. As with all of your patients, we know our employee will receive the best medical treatment possible.

We like our employees to stay at work or return to work as quickly as possible; therefore, we have designed and implemented a **Worker's Compensation Stay at Work/Return to Work Program** to meet the employee's physical and medical needs. We would appreciate your comments on this employee's ability to work. Please complete this form so that we can determine whether the employee may return to her/his regular position or, if necessary, offer a temporary modified position that best suits her/his physical and medical needs.

Very truly yours,
Human Resource Manager
ABC Company, Inc.

Telephone #555/217-6890 Fax #555/217-3476

Patient Name:	Social Security #: _________/__________/__________
Date of Accident: ________/________/_________	Diagnosis:

Patient is able to return to work **with** restrictions on: ______/_______/________
The capabilities below are: ☐ Temporary ☐ Permanent (If applicable, estimated length of time:_____________)
Patient is able to return to work **without** restrictions on: ______/_______/_______
Length of day patient can work: ☐ 4 hours ☐ 5-6 hours ☐ 7-8 hours ☐ 8+ hours

The patient can do the following:

Occasionally = 1 % - 33 %
Frequently = 34 % - 66 %
Continuously = 67 % - 100 %

Stand	☐ 8+ hours	☐ 5 - 6 hours	☐ 3 - 4 hours	☐ 1 - 2 hours
Sit	☐ 8+ hours	☐ 5 - 6 hours	☐ 3 - 4 hours	☐ 1 - 2 hours
Walk	☐ 8+ hours	☐ 5 - 6 hours	☐ 3 - 4 hours	☐ 1 - 2 hours
Intermittent Driving	☐ 8+ hours	☐ 5 - 6 hours	☐ 3 - 4 hours	☐ 1 - 2 hours
Continuous Driving	☐ 8+ hours	☐ 5 - 6 hours	☐ 3 - 4 hours	☐ 1 - 2 hours
Bend	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
Squat	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
Climb	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
Push	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
Pull	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
Driving	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
Reach above shoulder level	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
Reach below shoulder level	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None

Lifting Capabilities				
0 - 15 pounds	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
16 - 20 pounds	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
21 - 30 pounds	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
31 - 50 pounds	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
51 - 75 pounds	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
76 - 100 pounds	☐ Continuously	☐ Frequently	☐ Occasionally	☐ None
Hand Injuries Only (☐Major ☐Minor) **The patient can use hands for repetitive motion**				
A. Simple grasping Right hand Left hand	 ☐ Continuously ☐ Continuously	 ☐ Frequently ☐ Frequently	 ☐ Occasionally ☐ Occasionally	 ☐ None ☐ None
B. Fine Manipulation Right hand Left hand	 ☐ Continuously ☐ Continuously	 ☐ Frequently ☐ Frequently	 ☐ Occasionally ☐ Occasionally	 ☐ None ☐ None

General Comments:

Has the patient reached maximum medical improvement: ☐ Yes ☐ No

If yes, please give the date: ________/________/_________

The patient will be evaluated next on: ________/________/________

Is the injury causally related to employment? ☐ Yes ☐ No

Is the patient released from treatment? ☐ Yes ☐ No

Employer called by: Contacted: Date: _______/______/_______ Time:	Physician's Signature: Physician's Name (print): Address: Phone: ( )

Employee referred to specialist? ☐ Yes ☐ No
Name:
Address:
Phone: ( )

Appt. Date: _______/_______/______ Time:

PLEASE ASK EMPLOYEE TO SIGN THIS RELEASE

I authorize ***ABC Company, Inc.*** (or its representatives), to receive any information and facts regarding my injury, including reports and records, results of diagnosis, treatment and prognosis, estimates of disability and recommendations for further treatment. This information will be used to evaluate and handle my claim for the injury reported on this form and for no other purpose, now or in the future. I agree that a photographic copy of this release shall be as valid as the original.

Employee Signature ____ Date ________/__________/_________

ABC Company, Inc. Temporary Modified/Alternate Work Assignment Form

<table>
<tr><td colspan="4">STATUS AT TIME OF INJURY</td></tr>
<tr><td colspan="4">Employee Name:</td></tr>
<tr><td colspan="2">Home Address:</td><td colspan="2">Employee Clock #:</td></tr>
<tr><td colspan="2">City/State:</td><td colspan="2">Supervisor Name:</td></tr>
<tr><td colspan="4">TEMPORARY ALTERNATE WORK STATUS IF APPLICABLE</td></tr>
<tr><td colspan="2">Temporary Dept. Assigned:</td><td colspan="2">Temporary Supervisor:</td></tr>
<tr><td colspan="4">RESTRICTIONS</td></tr>
<tr><td colspan="2">Physician’s Name:</td><td colspan="2">Telephone: (   )</td></tr>
<tr><td colspan="2">Restrictions Until: _________/_________/_________</td><td colspan="2">Follow-up appt. date: __________/__________/__________</td></tr>
<tr><td colspan="4">Restrictions:</td></tr>
<tr><td colspan="4">DESCRIPTION OF EMPLOYEE’S PROGRESS</td></tr>
<tr><td colspan="4">Spoke to employee on: __________/__________/__________</td></tr>
<tr><td colspan="4">How is she/he feeling?</td></tr>
<tr><td colspan="4">Did she/he have any questions regarding her/his Workers Compensation benefits?</td></tr>
<tr><td colspan="4">Is she/he experiencing any problems?</td></tr>
<tr><td colspan="4">Has she/he seen the doctor this week? (Who & Where) What were the doctor’s instructions?</td></tr>
<tr><td colspan="4">Did she/he receive a doctor’s note? ☐ Yes ☐ No (If yes, please bring in or mail)</td></tr>
<tr><td colspan="4">Supervisor’s comments or concerns:</td></tr>
<tr><td>Employee’s Signature:</td><td>Group Leader’s Signature:</td><td>Supervisor’s Signature:</td><td>Other:
(Plant Mgr., Prod. Mgr., Gen. Sup.)</td></tr>
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Supervisor's Responsibilities

Procedure: As a Supervisor, you are responsible for providing a safe working environment and for reporting any unsafe conditions to management. These responsibilities include:

- Preventing accidents
- Investigating accidents
- Identifying temporary modified and alternate work
- Communicating with the injured employee and management

Accident Prevention: To prevent accidents and maintain worksite safety, be sure to:

- Set an example through your actions and attitude that stresses the importance of safety among employees
- Instruct Group Leaders, Foremen, etc., regarding their safety duties and periodically stress, as necessary, that these duties are to be performed along with other regular job functions.
- Assure that Group Leaders, Foremen, etc., maintain an effective program to: (1) educate their people on the hazards inherent in their jobs, (2) instruct them in safe work practices, and (3) train them so that they will motivate themselves to work safely
- Keep advised of safety conditions, practices and needs in the department through daily contact with your employees
- Conduct periodic inspections and make appropriate recommendations
- Identify and eliminate possible hazards in the workplace
- Participate in safety committees
- Ensure safe work practices

Post Injury Response: After an injury occurs, your response will affect **all** of your employees. As a Supervisor, you must:

- Take time to handle the injury promptly and thoroughly
- When applicable, escort the employee to the primary medical care facility
- Conduct the accident investigation promptly and record all pertinent information about the accident on the A.I.M. Mutual Supervisor's Report of Accident Investigation form
- Treat the employee as you would like to be treated: with dignity and compassion
- Ensure that corrective action is taken to eliminate conditions which cause the accident
- Keep informed on the medical progress of all employees under your supervision who have suffered a compensable injury
- Keep open at all times all lines of communication with management, the safety coordinator and all employees

Return to Work: In the event that an injured employee experiences temporary total disability, we must all work together to ensure an easy transition from disability to return to work. It is your responsibility as the injured employee's Supervisor to:

- Call the employee
- Ensure that the employee is receiving timely payments from the workers compensation insurance company
- Reassure the employee that the team needs him/her to return to work
- Welcome employees returning to work
- Think about abilities, not disabilities. What can the employee do?
- Coordinate appropriate modifications to the employee's regular job or, if necessary, provide a temporary alternate position within the employee's physical capabilities.
- Explain new duties carefully and emphasize the ***temporary*** nature of the alternate work
- Upon the employee's return, discuss how to prevent a similar accident in the future

Instructions to facilitate good communication between you, your employees and management:

1. Record all pertinent information about the accident on the A.I.M. Mutual's Supervisor's Report of Accident Investigation form in a timely manner.

   Be sure to fill in **all** sections; most importantly, "Why did this accident happen?", "What can be done to prevent this from happening again?"

2. If the employee is out of work, the Supervisor is expected to make a weekly telephone call to the injured employee. At the outset, ask how the accident occurred. This will enable you to make sure everything is reported to the insurance company right away and that all of the facts are correct. Also you should:

   • Ask how the employee is doing
   • Ask what ***ABC Company, Inc.*** can do to help
   • Ask if he/she has seen a doctor yet
      - if not, advise the employee to contact ***ABC Company, Inc's*** medical care provider as soon as possible or offer to call and make the appointment for him/her

      - if so, ask them the following:
         ⇨ whom did you see or where did you go for treatment?
         ⇨ What diagnosis did the doctor give?
         ⇨ What were the doctor's treatment instructions?
         ⇨ If the employee says he/she was told to rest, how long?
         ⇨ Did the doctor give you a disability note for us? (If so, tell the employee to send it in A.S.A.P. so you can send it along to the insurance company)
   - Ask the employee to call you after his/her follow up visit with the doctor.
   - Tell the employee to call us immediately of she/he has any questions or if she/he is experiencing any problems

3. If the employee is back to work, but in a modified or alternate duty position, the Supervisor is expected to meet with the injured employee and either the Plant Manager, Production Manager or General Supervisor, on a weekly basis until the employee returns to his/her original position.

   - When an employee is put on restricted duty by his/her primary physician, ***ABC Company, Inc.'s*** Temporary Alternate Work Assignment Form will be generated and given to the injured employee's Supervisor
   - The Supervisor should put this follow up form in a binder and keep it as a running log of his/her conversations with the employee
   - After each meeting, the Supervisor should photocopy the form and give it to the Human Resources Manager to be kept in the injured employee's file

A complete reassessment of a temporary modified or alternate work assignment should be conducted every thirty consecutive calendar days, at minimum. If the employee shows no signs of being able to return to his/her original work duties, the Supervisor, Plant Manager, Production Manager, General Supervisor and Human Resources Manager will need to meet to discuss a long-term or permanent resolution.