Injury Management Stay at Work or Return to Work

Sample Return to Work Forms

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A1 – Sample Disability Management Policy – Large Employer

Disability 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 Disability Management Program, incorporating modifies/alternate return to work, 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 their 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 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 Disability 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 Disability Management Policy – Small Employer

Disability 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 their 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.

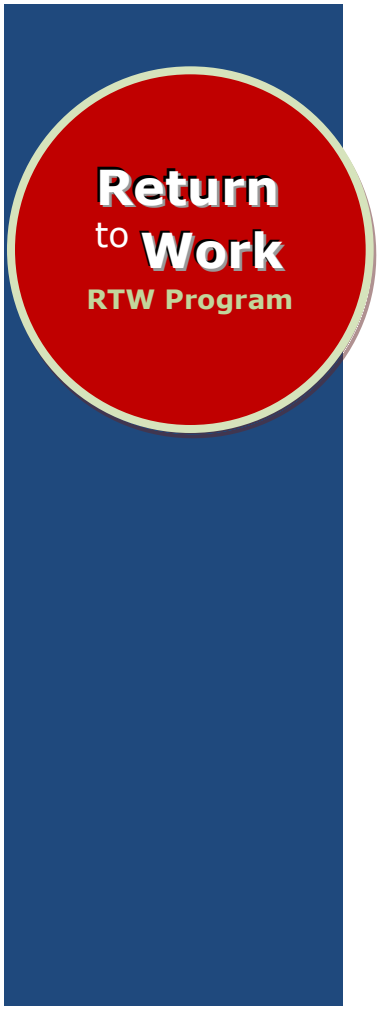
Date: _____ _____

Signatures: _____ _____

Owner **Worker Safety Representative**

[Company Logo] **Company Name**

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



An Exciting New Program!

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.

What's Involved?

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.

Benefits?

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.

Special Terms

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 maybe 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 program has 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 worker 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, 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 programs are 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 to his/her 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
On behalf of the employer

_____ Chief Steward
On behalf of employees

[Company Logo] **Company Name**

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, 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 programs are planned and documented with timelines

Safe and timely return to work recognizes that while an employee cannot perform the full range to his/her 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.

Sit	0 1 2 3 4 5 6 7 8 hours	I / C
Stand	0 1 2 3 4 5 6 7 8 hours	I / C
Walk	0 1 2 3 4 5 6 7 8 hours	I / C
Drive	0 1 2 3 4 5 6 7 8 hours	I / C
Bend	0 1 2 3 4 5 6 7 8 hours	I / C
	0 1 2 3 4 5 6 7 8 hours	I / C

Job Requirements

- ☐ **Squatting**
- ☐ **Kneeling**
- ☐ **Bending**
- ☐ **Twisting**
- ☐ **Reaching**
- ☐ **Crawling**
- ☐ **Ladder Work**
- ☐ **Stair Climbing**
- ☐ **Walking on rough ground**
- ☐ **Working at heights**
- ☐ **Exposure to heat or cold (circle)**
- ☐ **Exposure to dust, fumes or gases**
- ☐ **Exposure to high humidity**
- ☐ **Exposure to noise**
- ☐ **Repetitive movements**
- ☐ **Work above shoulder**
- ☐ **Work below shoulder**
- ☐ _____
- ☐ _____

Lifting Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10lbs	☐	☐	☐	☐
11 to 24lbs	☐	☐	☐	☐
25 to 34lbs	☐	☐	☐	☐
35 to 50lbs	☐	☐	☐	☐
51 to 74lbs	☐	☐	☐	☐
75 to 100lbs	☐	☐	☐	☐
Above 100lbs	☐	☐	☐	☐

Carrying Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10lbs	☐	☐	☐	☐
11 to 24lbs	☐	☐	☐	☐
25 to 34lbs	☐	☐	☐	☐
35 to 50lbs	☐	☐	☐	☐
51 to 74lbs	☐	☐	☐	☐
75 to 100lbs	☐	☐	☐	☐
Above 100lbs	☐	☐	☐	☐

Pushing Requirements

	Never	Occasionally	Frequently	Continuous
Up to 10lbs	☐	☐	☐	☐
11 to 24lbs	☐	☐	☐	☐
25 to 34lbs	☐	☐	☐	☐
35 to 50lbs	☐	☐	☐	☐
51 to 74lbs	☐	☐	☐	☐
75 to 100lbs	☐	☐	☐	☐
Above 100lbs	☐	☐	☐	☐

D2 – Sample Potential Light Duties

All Positions

- ☐ Safety person for welder, bobcat, construction projects
- ☐ Safety Orientations
- ☐ Monitor production rates
- ☐ Tool Crib Attendant
- ☐ Update manuals
- ☐ Review tool lists
- ☐ Training
- ☐ Job Safety Analysis
- ☐ Inventory
- ☐ Safety audits
- ☐ Update skills, First Aid, WHMIS, etc.
- ☐ Confined space monitoring

Carpenter

- ☐ Estimating
- ☐ Q.C. assistance
- ☐ Review/revise as built drawings
- ☐ Caulking
- ☐ Blocking & bridging
- ☐ Job scheduling assistant
- ☐ Review upcoming jobs
- ☐ Concrete/material takeoffs
- ☐ Deficiency lists
- ☐ Assist surveyor
- ☐ Safety inspections
- ☐ Work on table saw
- ☐ Install door hardware

Labourer

- ☐ Cleaning trailers or site
- ☐ Assist in office – photocopying, other clerical work
- ☐ Update and/or restock First Aid kits
- ☐ Safety inspections
- ☐ Picking up nails with magnet
- ☐ Fire extinguisher inspections
- ☐ Site access security / monitoring
- ☐ Driver
- ☐ Technical training
- ☐ Sweeping
- ☐ Pulling nails from wood
- ☐ Flag person/traffic control
- ☐ Swamper for equipment during moves
- ☐ Assist surveyor
- ☐ Helper on backfill
- ☐ Remove graffiti

Cement Masons

- ☐ Light finishing
- ☐ Concrete takeoffs
- ☐ Patching

[Company Logo] **Company Name**

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 their recovery.

3. **Other:**

Kindly forward this package to your physician and ask them 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 numbers they can call _____ at phone number (_____) _____.

After you have seen your physician, please contact your supervisor, _____, at phone number (_____) _____ to let them 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 towards your return to your regular duties.

Sincerely,

_____
Supervisor

_____
Phone Number

[Company Logo] **Company Name**

E2 – Sample Letter to Physician

To the Attending Physician,

Modified work programs assist in the rehabilitation, Stay at Work or an earlier Return to Work of employees with work related injuries while enabling companies to reduce the cost of injury and illness. The employee suffers no loss in remuneration and is assigned productive work, which take into consideration any physical restrictions, identified by you the medical practitioner. The modified work may consist of modifying the employees 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; or, providing an alternate productive job; or, providing a training opportunity; or, 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:

_____
_____
_____
_____

[Company Logo] **Company Name**

E3 – Sample Dear Physician/Physical Demands Letter 2

I authorize Dr. _____ to release medical information to my employer, but only that of 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 Dear 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 assist to 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

[Company Logo] **Company Name**

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 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:

[Company Logo] **Company Name**

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