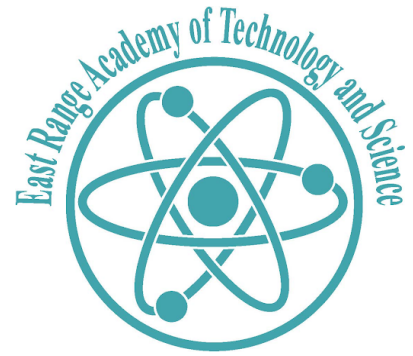


Board Policy
430

**Return to Work
Program**



Adopted: 10-30-2020

Revised: 12/7/2020

I. POLICY STATEMENT

East Range Academy of Technology and Science is committed to providing a safe and healthy working environment for all employees. As part of this commitment, we shall make every reasonable effort to provide suitable temporary employment to any employee unable to perform his or her job duties as a result of a workplace injury or illness. This may include a modification to the employee's original position or providing an alternative position, depending on the employee's medical restrictions, providing that this does not create an undue hardship to East Range Academy of Technology and Science. This program applies to all employees with work-related injuries and/or illnesses. Only work that is considered meaningful and productive shall be considered for use in the return to work program. Employees placed on a return to work plan will be expected to provide feedback in order to improve the program. All employees, regardless of injury or illness, will be considered for placement through the return to work program.

II. MEDICAL TREATMENT

If medical treatment is indicated, all employees injured at work should go to the appropriate medical provider for treatment as suggested by EMC OnCall Nurse (OCN). A list of East Range Academy medical providers is posted in the copy room, included in the employee packet, and available in the HR office.

III. TRANSITIONAL WORK

The list of ideas for common work restrictions is in Appendix C. This list will be used with the medical provider's restrictions to find work for all recovering employees.

Regular Work. If the medical restrictions do not exceed the recovering employee's regular job requirements, the employee can return to his or her usual job. If not, evaluate modified work options.

Modified Work. If the medical restrictions do exceed the recovering employee's regular job requirements, determine if changes can be made to the job to accommodate the employee. For example, an employee with a 20-pound lifting restriction will not be able to complete a job requiring him or her to lift a 30-pound box. We will attempt to work with this restriction using controls such as hoists, or by having another employee perform the lifting task in the interim.

Alternate Work. If job changes are not feasible, determine if other jobs are available within the facility that fall within the employee's restrictions. This may include jobs such as quality assurance inspections or non-routine jobs like filing papers or painting.

Transitional Work allows an employee with temporary work restrictions to work in a modified capacity for a defined period, while recuperating from an illness or injury.

Return to work programs can include modified work and/or alternate work, each of which will aid in the employee's transition back to full and normal work activities. It's important to remember that an employee's restrictions may change during their recovery, leading to changes to his/her temporary work assignments.

IV. PROGRAM RESPONSIBILITIES

Management. Management pledges their financial and leadership support for the Return to Work Program.

Program Administrator. The ERATS Operations Manager is the primary contact for the Return to Work Program, and is responsible for:

- Working with company team members to identify transitional work for recovering employees and recording the jobs in Appendix C
- Training supervisors and employees on the program. Training will be documented in Appendix K
- Reviewing the Return To Work Program periodically and making any needed changes or updates using Appendix J and recording those changes in the Revision History section
- Following all steps outlined in Appendix F when an employee is injured on the job

Supervisors must follow all steps outlined in Appendix G when an employee is injured on the job.

Recovering Employees must follow the steps outlined in Appendix H if injured on the job.

V. PERMANENT JOB MODIFICATIONS

In the event an injury results in permanent medical restrictions, we will work with our insurance carrier to determine the best course of action. In some cases, this may include reasonable accommodations made to the worker's regular job or the placement of the employee in a position that is suitable to their permanent restrictions.

VI. TRAINING

Training should include the following topics:

- Purpose and detail of the Return To Work Program
- How to fill out necessary return to work forms
- The step-by-step process to follow when an injury occurs
- Where to go for treatment if injured on the job
- How to report any work restrictions prescribed by the provider
- How to report any concerns with performing transitional work duties

Appendix A – Employee Work Injury Report

You, the injured employee, are responsible for answering all questions on the Employee's Work Injury Report accurately and in detail. This completed report should be given to the Program Administrator at the end of your shift or working day of your work-related injury.

**THIS FORM DOES NOT REPLACE THE FIRST REPORT OF INJURY (FROI).
THE FROI IS REQUIRED BY THE STATE TO INITIATE A WORKERS' COMPENSATION CLAIM.**

Employee Work Injury Report

Personal Information

Name _____ Social Security Number _____
Address _____ Birth Date _____ Sex M ☐ F ☐
City, State _____ Zip _____ Telephone _____
Married ☐ Single ☐ Number of Dependents _____ Home/School _____
Family Physician _____ Telephone Number _____
Are you currently entitled to Medicare Benefits? Yes ☐ No ☐ Medicare # (HICN) _____
Have you applied for Medicare or SSDI? Yes ☐ No ☐ Pending ☐ Rejected ☐

Employment Information

Job Title _____ Employment Date _____
Salary/Hourly Rate _____ Hours Worked Per Day _____
Building Location _____ Time Work Day Begins _____

Injury/Illness

Date of Injury _____ Time of Accident _____
Where in the facility/job site did this injury occur? _____
What were you doing when injured? _____
How did the injury occur? _____

Describe the injury or illness in detail and indicate the part of the body affected. (Designate right or left if appropriate)

Any previous similar injury? If yes, explain. _____
Was this injury witnessed? If so, by whom? _____
Did you lose time from work? Yes ☐ No ☐ Date(s) missed _____
Have you returned? Yes ☐ No ☐ If yes, what was the date? _____

Treatment

Medical Facility _____
Diagnosis/Care Prescribed _____

Contact

When you return to work, you must call Office Manager and your management will notify your assigned claim adjuster.

Employee Name (PRINTED) _____ Date _____
Employee's Signature _____

Appendix B – Medical Provider Work Related Injury/Illness Report (complete after each visit)

Date of Service: _____ Patient Name: _____ Employer: <u>East Range Academy of Technology and Science</u>		PLEASE FAX IMMEDIATELY TO BOTH: Fax: _____ Insurance Company Fax: _____ Notified: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diagnosis: _____		Is condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment Plan: _____			
Medication(s): _____			
Date of most recent examination by this office: ____/____/____. The next scheduled visit is: <input type="checkbox"/> as needed OR ____/____/____.			
		<small>Month/Day/Year</small>	
1. <input type="checkbox"/> Recommended his/her return to work with no limitations on _____.			
<small>Date</small>			
2. <input type="checkbox"/> He/She may return to work on _____ with the following limitations:			
<small>Date</small>			
DEGREE		LIMITATIONS	
<input type="checkbox"/> Sedentary Work. Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.		1. In an 8 hour work day, patient may: a. Stand/walk <input type="checkbox"/> None <input type="checkbox"/> 4-6 Hours <input type="checkbox"/> 1-4 Hours <input type="checkbox"/> 6-8 Hours b. Sit <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours c. Drive <input type="checkbox"/> 1-3 Hours <input type="checkbox"/> 3-5 Hours <input type="checkbox"/> 5-8 Hours	
<input type="checkbox"/> Light Work. Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.		2. Patient may use hands for repetitive: <input type="checkbox"/> Single grasping <input type="checkbox"/> Pushing and pulling <input type="checkbox"/> Fine manipulation	
<input type="checkbox"/> Medium Work. Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds.		3. Patient may use feet for repetitive movement as in operating foot controls: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Heavy Work. Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.		4. Patient is able to: <div style="display: flex; justify-content: space-around;"> <u>Frequently</u> <u>Occasionally</u> <u>Not at all</u> </div> a. Bend <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> b. Squat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> c. Climb <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> Very Heavy Work. Lifting objects in excess of 100 pounds with frequent lifting and/or carrying of objects weighing 50 pounds or more.			
OTHER INSTRUCTIONS AND/OR LIMITATIONS:			
3. <input type="checkbox"/> These restrictions are in effect until _____ or until patient is reevaluated.			
<small>Date</small>			
4. <input type="checkbox"/> He/She is totally incapacitated at this time. Patient will be reevaluated on _____.			
<small>Date</small>			
Treating Facility Name: _____		Please Print	
Physician's Signature: _____		Phone No: (____) _____	
RELEASE OF INFORMATION AUTHORIZATION			
I authorize the treating physician to release copies of my medical records including lab and x-ray reports to the above-named employer and the insurance company. I certify that I have received a copy of this report.			
Employee's Signature: _____		Date: _____	

Appendix C – Transitional Work List

The following list outlines preplanned opportunities for transitional work. Tasks selected for a recovering employee must be consistent with their work restrictions provided by the medical provider. The treating provider should be consulted to verify the tasks are appropriately matched to the worker's current abilities. Additional tasks that may be appropriate for this list should be sent to the Program Administrator for approval.

Use the Department of Labor guidelines to fill in the job task requirements (number of repetitions or percentage of time can be used).

Frequency Abbreviation	Number of Repetitions During Shift	Percentage of Time
Rare to Occasional (R/O)	0-20	33%
Frequent (F)	20-100	33-66%
Constant (C)	100	66-100%

Job	Requirements							
	Lift/ Carry (lbs)	Stand/ Walk	Sit	Drive	Grip	Bend	Squat	Climb
Office Support (Paperwork)	R/O	R/O	C	R/O	F	R/O	R/O	R/O
Office Support (Computer)	R/O	R/O	C	R/O	F	R/O	R/O	R/O
Academic Support (Paper and/or Computer Based)	R/O	R/O	C	R/O	F	R/O	R/O	R/O
Working with Students	R/O	F	F	R/O	F	F	R/O	R/O
General Labor Around the Building (cleaning, organizing, cafeteria)	F	C	R/O	R/O	C	C	F	R/O
Data Analysis Project	R/O	R/O	C	R/O	R/O	R/O	R/O	R/O

Appendix D – Temporary Transitional Job Offer Letter

Date: _____

East Range Academy of Technology and Science
2000 Siegel Blvd.
Eveleth, MN 55734

Dear _____,

We are pleased to offer you temporary transitional work as part of our Return to Work Program while you are recovering from your injury. It is our goal that this temporary assignment will aid in your transition back to full work activities. Your doctor has released you to perform certain work activities, which we have considered when creating your temporary position. We will only assign tasks consistent with your physical abilities, knowledge, and skills and will provide training if necessary.

Start Date:

Planned Work Schedule

Location: East Range Academy

Supervisor Name:

Job Title/Tasks (including physical requirements):

Wage Rate:

Details of Applicable Lodging/Meals/Transportation Compensation and any changes to benefits package:

Please complete the following sections on the next page: 1) acknowledgement of receipt of this letter and 2) acceptance/refusal of the temporary transitional job offer. If you refuse the temporary transitional work offer, you must communicate the reason for the refusal in the space provided. Please sign and return both pages of this letter to me by _____ and retain a copy for your records.

If we do not receive this acknowledgment form from you by _____, or if you refuse the temporary transitional work that has been offered to you, your rights to further workers' compensation benefits may be affected. Please let me know if you have any questions or concerns.

Sincerely,

[NAME]
Operations Manager

Acknowledgement of Receipt of This Letter:

My signature below acknowledges receipt of this letter and offer of temporary transitional work:

Your Signature _____ Print Name _____

Date _____

Acceptance/Refusal of the Temporary Transitional Job Offer:

By checking the appropriate box below, I accept or refuse this temporary transitional work offer:

☐ Accept

☐ Refuse (you must communicate the reason for the refusal in the space provided):

Your Signature _____ Print Name _____

Date _____

** Please sign and return both pages of this letter to me by _____ and retain a copy for your records.*

Appendix E – Letter to Treating Provider

Date:

East Range Academy of Technology and Science
2000 Siegel Blvd.
Eveleth, MN 55734

Dear

_____ is employed by East Range Academy of Technology and Science as a
_____. He/she was injured on _____.

East Range Academy of Technology and Science has a *Return to Work Program* that is designed to safely return our recovering employees to work as soon as possible.

If _____ is unable to return to work in their original position and capacity, we will make every effort to provide modified or alternative work. Enclosed you will find a copy of the job description, which outlines essential job functions, and a work-related injury/illness report. Please fill out the work-related injury/illness report so we will have a better understanding of our employee's work restrictions. We will ensure that any modified or alternative positions meet all of your prescribed medical restrictions. Please fax the work-related injury/illness report back to our office at 218-744-2349.

Please contact me if you have any questions at 218-744-7965. We appreciate your participation in our efforts to return our employees to a safe, productive workplace.

Sincerely,

[NAME]
Operations Manager

Enclosures:
Original Job Description
Modified Job Description
Work Related Injury/Illness Report

Appendix F – Program Administrator Checklist

Follow the steps below when an employee is injured on the job.

- ☐ Monitor and support the supervisors in providing prompt medical care to injured workers.
- ☐ Be prepared to provide additional information regarding the injured employee to the claims adjuster.
- ☐ Review the Work-Related Injury/Illness Report from the medical provider with the recovering employee's supervisor and find transitional work within his/her work restrictions using the following priority: regular work, modified work and alternate work.
- ☐ If you did not receive medical restrictions or a release to full duty from either the recovering employee or the medical provider, contact the provider and collect the work restrictions or release to full duty with the doctor's signature.
- ☐ Call the recovering employee to invite them back to work.
- ☐ Provide the recovering employee with Written Transitional Job Offer outlining the duties of the transitional position, start date, hours and work tasks.
- ☐ Receive signed copy of the Written Transitional Job Offer from the employee.
- ☐ Send a copy of the signed Written Transitional Job Offer to EMC Insurance Companies.
- ☐ File a copy of the signed Written Transitional Job Offer in a folder separate from the employee's HR folder.
- ☐ After employee returns to work, check in with them daily and remind them to only work within the prescribed restrictions.
- ☐ Report recovering employee's work hours to the insurance claims adjuster weekly.
- ☐ Send Transitional Work Log to EMC Insurance Companies.
- ☐ Contact EMC Insurance Companies regarding any changes to the employee's work restrictions or if they are not adhering to the prescribed restrictions.
- ☐ If restrictions change, update the employees transitional work assignment.
- ☐ Send employee a new Written Transitional Job Offer if transitional work changes.

NOTE: An employee may be disqualified from receiving workers' compensation benefits if they refuse to return to work after a provider has cleared them for work. If a situation like this arises, contact your insurance claims adjuster for guidance.

Appendix G – Supervisor Checklist

Follow the steps below when an employee is injured on the job.

- ☐ Instruct the injured worker to call the EMC OnCall Nurse for injury triage and to report the worksite injury. If the injured worker is unable to report the injury, you can call the OnCall Nurse to report the injury.
- ☐ Ensure all employees follow recommended medical treatment instructions provided by EMC OnCall Nurse.
- ☐ Make sure the recovering employee has the Work-Related Injury/Illness Report and gives it to the treating provider.
- ☐ Contact employee and ask if they have received, reviewed, signed and returned the Written Transitional Job Offer.
- ☐ Assist Program Administrator in identifying transitional work within the recovering employee's work restrictions. (Under no circumstances should an employee be assigned to work that exceeds the medical provider's restrictions).
- ☐ Ensure all employees are adhering to their work restrictions.
- ☐ Once the employee has returned to work, report any concerns they have with completing their work to Program Administrator.
- ☐ Assist Program Administrator with reporting the recovering employee's work hours to the insurance claims adjuster weekly.

Appendix H – Employee Checklist

Follow the steps below when injured on the job.

- ☐ Participate in the OnCall Nurse process.
- ☐ Follow recommended medical treatment instructions provided by EMC OnCall Nurse.
- ☐ For non-emergency medical treatment and follow-up care give the Work-Related Injury/Illness Report to the provider.
- ☐ Provide Program Administrator and Supervisor with information about their work restrictions or changes to work restrictions after each provider visit (including full release with no restrictions).
- ☐ Receive a verbal and/or Written Transitional Job Offer.
- ☐ Review the Written Transitional Job Offer, sign and return to the Program Administrator.
- ☐ Return to work on the agreed upon date.
- ☐ Perform assigned transitional work. This may be in a different role or department than normal.
- ☐ Only perform work activities within the restrictions, both on and off the job.
- ☐ Follow Human Resources policies related to punctuality, attendance and job performance.
- ☐ Report any concerns you have completing your transitional work to the Program Administrator, even if it is within the current restrictions.
- ☐ Report all transitional work hours to the Program Administrator and your supervisor.
- ☐ Attend all scheduled medical, therapy and other related appointments, and follow all medical advice.
- ☐ Return to regular work when approved by the medical provider.

NOTE: You may be disqualified from receiving workers' compensation benefits if you refuse to return to work after a provider has cleared you for work.

Appendix I – Transitional Work Log

Fill out this log each day accounting for all work performed by the recovering employee. Send a copy to your insurance carrier weekly and retain a copy in a folder separate from the employee's HR file.

Organization Name:	East Range Academy of Technology and Science
Date:	
Employee Name:	
Supervisor Name:	
Hourly Wage:	

Date	Start/Stop Time	Transitional Work Performed	Concerns With Work

Appendix J – Annual Program Evaluation Report

Date of Evaluation:	Evaluated By (list all present):
Written Program Reviewed: Yes No	
Comments on Written Program:	
The following specific procedures have been reviewed:	
The following specific procedures were modified:	
The following specific procedures were added:	
A review of the accident reports and injury and illness reports were made: Yes No	
The following additional expense(s) resulted from failure to use correct return to work procedures:	
Comments:	

Appendix K – Training Record for The Return to Work Program

The following individuals received training on the Return to Work Program.

Print Name	Sign Name

The undersigned conducted training in accordance with East Range Academy of Technology and Science's Return to Work Program.

Print Instructor's Name	
Instructor's Signature	
Instructor's Title	
Date of Training	