TRANITIONAL RETURN-TO-WORK POLICY STATEMENT

Our goal is to minimize serious disability and loss of wages to employees in the event they are injured on the job. If possible, we will help our employees return to lighter, transitional tasks to help them build towards assuming their regular job as quickly as possible. The temporary transitional tasks will depend on the employee's work restrictions. These tasks may consist of the employee's regular job, modified to accommodate his/her restrictions and/or a different set of tasks that exist in the work place.

These tasks may be assigned on a different shift or in a different area or department. The temporary transitional tasks job offer will be made only when the tasks are available and are a benefit to us and our employees. If offered, the temporary tasks would be available for up to 90 days or longer depending on the injured worker's medical progress and our business circumstances.

We will work with our injured workers and their medical providers so that we may develop an appropriate on-the-job rehabilitative plan. Our goal is to provide productive tasks and help employees return to their regular job at the earliest opportunity.

Transitional Return-To-Work policy for workers' compensation claims.
REMEMBER:

Internal Use Only

✓ **Claim File:** Copy the forms enclosed in plastic and place in individual file folders with a copy of the State workers' compensation claim form to have a ready supply of claim packets.

✓ Treat your employees with respect.

✓ Promptly inform employees about claim benefits. Let them know their recovery and wellbeing are of the utmost importance.

✓ If you doubt the validity of the injury, provide the carrier signed, dated and witnessed statements with a copy of your factual, objective, thorough investigation.

✓ Insist your claims examiner is respectful and helpful to your employee.

✓ Establish relationships with quality occupational medical providers. These providers should use a sports medicine approach to rehabilitation and treat your employees with genuine concern.

✓ Set up a gradual, progressive work hardening program for all your injured workers to increase duties to pre-injury levels within physician guidelines.

✓ If you have performance/attendance problems with an injured worker, please document all interactions and call your Human Resources Manager before considering termination.

✓ All personnel actions and attorney requests need to be reviewed by HR before any action is taken.

✓ Remember that all information, written or verbal that you share with the carrier, may be discoverable.

✓ **COMMUNICATE EARLY, OFTEN AND FULLY TO ALL INVOLVED!**
## INJURED WORKERS’ CLAIM MANAGEMENT CHECKLIST
- Washington -

**Internal Use Only**

**Injured Worker:**

### Getting Started
Prepare employee accident folders with all necessary forms = Claim File

<table>
<thead>
<tr>
<th>Forms</th>
<th>Injured worker DOES NOT SEEK Medical attention - Complete the following forms:</th>
<th>Done</th>
</tr>
</thead>
</table>
| EE Incident report Employer Investigation | - Employee and Executive Director complete forms  
- Make OSHA 300 & 301 Log Entries - See first aid injury instructions  
- REMOVE WORKER’S NAME - Route a copy to the Safety Committee  
- File in Claim File. Must keep for 5 years, Healthcare Facility 7 Years | |

<table>
<thead>
<tr>
<th>Forms</th>
<th>Injured worker SEeks Medical attention - Continue to follow the steps below:</th>
<th>Done</th>
</tr>
</thead>
</table>
| Utilize your Preferred Occupational Health Facility | Take worker for treatment  
Use your preferred provider. | |
| Claim File | - Establish Claim File to be kept SEPARATE from Personnel files | |
| KPD Incident Tracker | - Enter incident on Incident Tracker and complete weekly updates | |
| Claim Activity Doc | Keep copies of ALL claim related paperwork and document ALL interactions with injured worker, physician or carrier (Phone, fax, email or other) | |
| Supervisor’s Injury Report | - Complete and Fax to ERNWest and Corporate  
- Copy injured worker  
- Place in Claim File and enter info in Incident Tracker | |
| Understanding Workers’ Compensation Claims | - Give to injured worker for his/her records | |
| Employee Responsibilities | - Complete - copy to injured worker  
- File in Claim File and enter info in Incident Tracker | |
| WHCA Tri-fold | - Complete sign and date. Have injured worker take to physician’s office at initial visit or fax to the physician.  
- Send the physician completed and signed copy to ERNWest and Corporate  
- Place in Claim File and enter info in Incident Tracker | |
| Valid Job Offer | - Complete after physician has signed off on modified duty tasks  
- Review and sign with employee or mail to employee for signature  
- Via regular and certified mail with a copy to ERNWest and Corporate  
- Place in Claim File and enter info in Incident Tracker | |
| Subsequent visits for treatment of injury | - WHCA Tri-fold completed at each visit  
- New valid job offer letter completed and signed when restrictions change  
- Paperwork faxed to ERNWest and Corporate  
- Place in Claim File and enter info in Incident Tracker | |
| Regular Work Release | You must get a regular work release from physician  
- Copy ERNWest and Corporate  
- Place in Claim File and enter info in Incident Tracker | |
| Regular Job Description | Complete at insurers request-contact corporate claims manager for assistance | |
| Notice of Closure | - Place in Claim File and enter info in Incident Tracker | |

### TO DO / Follow up

1) Check to make sure injured worker is performing full regular duties  
2) If unable to perform full regular duties without problems, call Advantage Health  
3) Double check that safety issue has been corrected.

**Postings**

Required Postings may be obtained from www.boil.state.or.us/BOLI/CRD/c_postings.shtml
**EMPLOYEE REPORT OF INCIDENT / ACCIDENT**

Employee: Fill out this report for all workplace incidents or accidents, no matter how minor. Give completed form to your supervisor. Failure to report an incident at the time it occurs may result in disciplinary action.

Attach additional sheets if more space is needed to completely & accurately document the incident.

<table>
<thead>
<tr>
<th>Date of this report:</th>
<th>Report is for: Injury  Close Call  Other:</th>
</tr>
</thead>
</table>

**WHO WAS INVOLVED OR INJURED?**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Witnesses:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>1)</td>
</tr>
<tr>
<td></td>
<td>2)</td>
</tr>
<tr>
<td>Phone #:</td>
<td>3)</td>
</tr>
<tr>
<td>Job title:</td>
<td>How long have you been in this job?</td>
</tr>
</tbody>
</table>

**WHAT HAPPENED? (describe-attach a separate page if necessary)**


**WHY DID THIS HAPPEN AND HOW COULD IT BE PREVENTED?**


**WHERE DID THE INCIDENT / ACCIDENT OCCUR? (Be specific; include resident apt # if applicable).**

<table>
<thead>
<tr>
<th>Dept:</th>
<th>Location:</th>
<th>Equipment:</th>
</tr>
</thead>
</table>

Did you seek medical treatment other than first aid?  *Yes  No

*If the answer is yes, additional forms must be completed, see checklist.*

**WHEN DID THE INCIDENT / ACCIDENT OCCUR?**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Exact Time of Day:</th>
<th>AM/PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Scheduled Shift on this day:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employee Signature: ________________________________
EMPLOYEE RESPONSIBILITIES
REGARDING ON-THE-JOB INJURIES / ACCIDENTS

1. Report all accidents/injuries, no matter how slight, to your Executive Director and complete the Incident/Accident Report. Failure to complete the Incident/Accident report may result in disciplinary action. Consult with the company nurse to help you determine if medical treatment is necessary. Your Executive Director or designee will take you to the clinic. If it is after hours and immediate treatment is necessary, they will assist you in finding appropriate care.

2. If you see a doctor, complete the “worker” portion of the State Workers’ Compensation Claims form. Your Executive Director will give you the form and, if needed, help you complete the form.

3. Take the Modified Temporary Work form to the physician. You need to have the physician complete this information at the time of your visit. Return form to your Executive Director. Inform the physician that we have a “No Time Loss” philosophy and we will attempt to provide modified duty to fit almost any restrictions.

4. Report your physician’s findings to your Executive Director immediately following your visit. If you have work restrictions, we will make a plan specifically for you according to the restrictions from your physician.

5. Once your Doctor releases you to work, you must report to your next scheduled shift. This includes part-time, temporary, modified or regular work. You are expected to always work within the restrictions your physician has given you and not to exceed those restrictions outside of work.

6. If the physician does not release you to return to any type of work, it is your responsibility to contact your Executive Director on a weekly basis. Please come into the facility every TUESDAY to meet with your Executive Director between 9:00am and 12:00pm.

7. Follow-up medical appointments should be scheduled outside of work hours. You must keep your Executive Director informed of all appointments and give him or her the updated Release to Return to Work form after each visit.

8. We want to work with you to help you get better. If you have any questions or concerns regarding your claim or medical care, please contact your Executive Director.

I have read the above responsibilities. I have been given the opportunity to ask questions about my responsibilities. I agree to follow these responsibilities and understand that failure to do so may result in termination of, or may adversely affect, my workers’ compensation benefits. I have been given a copy of this document.

_________________________  _______________________
Employee’s Signature       Date
INCIDENT / ACCIDENT INVESTIGATION

Executive Director: Fill out this report for all workplace incidents or accidents, no matter how minor. Document the incident and your investigation in KPD website. Attach additional sheets if more space is needed to completely & accurately document the incident.

<table>
<thead>
<tr>
<th>Date of this report:</th>
<th>Date incident reported:</th>
</tr>
</thead>
</table>

**WHO WAS INVOLVED OR INJURED?**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Witnesses:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>1)</td>
</tr>
<tr>
<td>Phone #:</td>
<td>2)</td>
</tr>
<tr>
<td>Job title:</td>
<td>3)</td>
</tr>
</tbody>
</table>

**Time on this job:**

**WHAT HAPPENED?** (describe-attach a separate page if necessary)


**WHERE DID THE INCIDENT / ACCIDENT OCCUR?** (Be specific; include resident apt # if applicable).

<table>
<thead>
<tr>
<th>Dept:</th>
<th>Location:</th>
<th>Equipment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was first aid provided? Yes No</td>
<td>If yes, who provided first aid?</td>
<td></td>
</tr>
</tbody>
</table>

Did the employee seek medical treatment other than first aid? *Yes No

*If the answer is yes, additional forms must be completed, see checklist.

**WHEN DID THE INCIDENT / ACCIDENT OCCUR?**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Exact Time of Day:</th>
<th>AM/PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee’s shift on this day:</td>
<td></td>
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</tr>
</tbody>
</table>

Did the employee complete his/her shift? Yes *No

*If the answer is No, what time did employee leave work? 

Was employee paid for full shift? Yes No
WHY DID THE SITUATION DEVELOP THAT LED TO THE INCIDENT / ACCIDENT? (get all the facts by studying job and situation involved. Don’t limit yourself to one reason. Consider training and accountability. Question the use of WHAT – WHO – WHERE – WHEN – WHY – HOW. Attach separate page if necessary) When you think you know the answer, ask WHY again.


HOW CAN A SIMILAR INCIDENT / ACCIDENT BE PREVENTED? WHAT SHOULD BE DONE TO CORRECT THE HAZARD? Be specific.


PEOPLE RESPONSIBLE FOR CORRECTIVE ACTION: DATE:

INVESTIGATED BY: DATE:

REVIEWED BY: DATE:

REVIEWED BY: SAFETY COMMITTEE

SIGNATURE: DATE:

This form to be retained for seven (7) years. Executive Director: Complete report and document incident in Risk Solutions.
CLAIM ACTIVITY DOCUMENTATION

Document ALL claim activities. For internal use only
(Interactions with the injured worker, claims examiners and medical providers)

<table>
<thead>
<tr>
<th>INJURED WORKER:</th>
<th>CLAIM #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE OF INJURY:</td>
<td>INS. CO:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Description of Action / Activity</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tr>
</tbody>
</table>

Please staple to the left side of your WC File.
EMPLOYER'S Commitment to the Team

- Investigate all incidents to identify if any safety enhancement can be made to prevent similar incidents in the future.
- Employees will not lose their job because as the result of reporting an industrial injury.
- We will make reasonable efforts to maintain your current employment and pay/benefit level.
- Provide temporary modified-duty work to assist in your recovery efforts.
- Work with you, your doctor, and L&I to make sure your claim for benefits is processed in a timely manner.
- Help you receive the best medical care available for your work-related condition.
- Work with you and L&I to ensure timely payments on your claim.

EMPLOYEE'S Commitment to the Team

- Give this pamphlet to your treating doctor at the first visit.
- Return this pamphlet to __________________ (supervisor or supervisor's designee) within one (1) business day of being seen by your doctor.
- Follow the treatment plan prescribed by the treating doctor.
- Follow the restrictions provided by your treating doctor in both work and non-work related activities to help ensure a safe and swift recovery.
- Make all reasonable efforts to return to work as quickly and safely as possible.
- Within one (1) business day of each medical appointment hand-deliver new physical restrictions or disability certification to your supervisor or their designee.

________________________________________

I have read and understand my responsibilities and agree to follow these responsibilities and all company policies.

Employee's Signature

Date Signed

Employer Signature

Date Signed

Our Commitment Regarding On-the-Job Injuries

You are a valuable member of this company's team and we need to work together to return to work as quickly and safely as possible. Please join us in our commitment to accomplish this.

We have made every attempt to make this return-to-work program as easy as possible for all parties involved. The steps in the process are as follows:

1) Review this pamphlet with your employer and doctor.

2) Take this pamphlet to your doctor appointment and have him/her fill it out in front of you.

3) Return this to your supervisor, in person within one (1) business day of your appointment.

4) Continue to return every disability certificate or work restriction in person, provided it is medically reasonable, to your supervisor.
Return to Work Job Analysis and Medical Information

We are committed to returning our team member back to work as soon as medically possible and we need your help! Please give this document back to our employee during your visit with them, they are required to return this to us within one (1) business day so we can try and assist in their rehabilitation by providing modified work. **YOU CAN BILL FOR FILLING OUT THIS FORM BY USING L&I CODE M1037.**

---

**Employee:** ____________________________ **Company:** ____________________________ **L&I Claim No.:** ____________________________

**Date of injury:** _______________ **Today's date:** _______________ **Return visit on:** _______________ **First injury/condition of this type?** □ Yes □ No

**Initial Diagnoses:** ____________________________ **Estimated full-duty release date:** _______________

**Treatment Plan (check all that apply)**

- [ ] Physical Therapy ______ times per week, for _____ weeks
- [ ] Occupational Therapy ______ times per week, for _____ weeks
- [ ] Surgery - anticipated date
- [ ] X- Ray □ MRI □ CT Scan □ EMG □ Other ____________________________

**Referral to other providers:** □ None □ Neurology □ Orthopedic Surgeon □ Psychiatrist/Occ. Med. □ Rheumatologist □ Other ____________________________

---

We have identified four (4) stages of modified duty, please check the appropriate stage our employee is able to perform and cross out any task our employee should not be performing.

- [ ] Stage 1: Tasks may include feeding residents, serving trays, folding laundry, assisting residents with all forms of hygiene, taking vital signs, adjusting bed heights, straightening bedside tables and closets, organizing drawers, dusting, delivering mail, resident activities, light clerical functions, review flow sheets and list changes needed in resident care area and other duties within the physical demands described below.

<table>
<thead>
<tr>
<th>Standing:</th>
<th>Rare/Occasional</th>
<th>Carrying:</th>
<th>1 - 10 lbs.</th>
<th>Grasping/Handling:</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting:</td>
<td>Rare/Occasional</td>
<td>Lifting:</td>
<td>1 - 10 lbs.</td>
<td>Bending/Squatting:</td>
<td>Occasionally</td>
</tr>
<tr>
<td>Walking:</td>
<td>Rare/Occasional</td>
<td>Push/Pull:</td>
<td>1 - 10 lbs.</td>
<td>Twisting/Climbing:</td>
<td>Rare</td>
</tr>
</tbody>
</table>

- [ ] Stage 2: Tasks may include all of stage 1 and labeling beds and drawers, assisting with serving at meal time, clean bathroom sinks, cleaning dishes and tables, monitor and chart weights and vital signs, changing bedding, all clerical functions, assist residents with dressing & hygiene, stock utility rooms with clean linens, deliver resident laundry, assists in preparing meals and meal trays and other duties within the physical demands described below.

<table>
<thead>
<tr>
<th>Standing:</th>
<th>Occasionally</th>
<th>Carrying:</th>
<th>11 - 25 lbs.</th>
<th>Grasping/Handling:</th>
<th>Continuously</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking:</td>
<td>Occasionally</td>
<td>Push/Pull:</td>
<td>11 - 25 lbs.</td>
<td>Twisting/Climbing:</td>
<td>Rare</td>
</tr>
</tbody>
</table>

- [ ] Stage 3: Tasks may include all of stages 1 and 2 as well as transporting linen, make beds, assist in turning mattresses, wash walls, vacuuming, clean floors in all areas using broom and mop, cleaning of equipment, empty trash, assist residents to and from activities, push wheelchair chairs and four wheeled carts, touch up painting and other duties within the physical demands described below.

<table>
<thead>
<tr>
<th>Standing:</th>
<th>Frequently</th>
<th>Carrying:</th>
<th>26 - 50 lbs.</th>
<th>Grasping/Handling:</th>
<th>Continuously</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting:</td>
<td>Occasionally</td>
<td>Lifting:</td>
<td>26 - 50 lbs.</td>
<td>Bending/Squatting:</td>
<td>Occasionally</td>
</tr>
<tr>
<td>Walking:</td>
<td>Frequently</td>
<td>Push/Pull:</td>
<td>26 - 50 lbs.</td>
<td>Twisting/Climbing:</td>
<td>Rare</td>
</tr>
</tbody>
</table>

- [ ] Stage 4: Return to full duty no restrictions

---

**DEFINITIONS**

<table>
<thead>
<tr>
<th>Rare:</th>
<th>0% - 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occasional:</td>
<td>11% - 33%</td>
</tr>
<tr>
<td>Frequent:</td>
<td>34% - 66%</td>
</tr>
<tr>
<td>Constant:</td>
<td>67% - 100%</td>
</tr>
</tbody>
</table>

WAC 296-19A-030 requires doctors to respond to requested information in a timely manner, which includes physical capabilities or restrictions.

---

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SUPERVISOR'S INCIDENT REPORT

Company Name: 

OSHA Log case number: 
(Transfer the case number from the Log after recording the case)

Was the incident fatal? [ ] Yes [ ] No

Was employee given first aid? [ ] Yes [ ] No

PART I – TO BE COMPLETED BY SUPERVISOR

Employee:

Date of Injury:

Date Reported to Supervisor:

Home or Mailing Address:

Occupation:

Time of Injury: AM/PM

Location:

Time Reported: AM/PM

Reported To Whom:

Home Phone:

[ ] Male [ ] Female

Time employee began work ___________________ AM / PM

Date of Hire:

Date of Birth:

[ ] Emergency Room [ ] Urgent Care [ ] Other

Treating Caregiver's Name, Address & Phone:

Was employee placed on modified duty? [ ] Yes [ ] No

Will employee lose time from work? [ ] Yes [ ] No

If lost time, approximate number of days __________________________

Was worker hospitalized overnight? [ ] Yes [ ] No

Was treatment refused? [ ] Yes [ ] No

Supervisor – Describe in detail what employee was doing just before the incident occurred including the activity, tools, equipment, and/or material being used:

Supervisor – Describe how the injury occurred including the activity being performed and objects, people associated with the injury:

Part of Body (Circle side if applicable)

[ ] Head
[ ] Eyes (L or R)
[ ] Nose
[ ] Mouth
[ ] Ear
[ ] Shoulder (L or R)
[ ] Back
[ ] Chest
[ ] Arm (L or R)
[ ] Hip

[ ] Hand (L or R)
[ ] Finger
[ ] Leg (L or R)
[ ] Foot (L or R)
[ ] Toes
[ ] Internal
[ ] Multiple
[ ] Ankle (L or R)
[ ] Wrist (L or R)
[ ] Face

[ ] Knee (L or R)
[ ] Abdomen
[ ] Entire
[ ] Glasses
[ ] Teeth
[ ] Groin
[ ] Neck
[ ] Elbow (L or R)
[ ] Rib

Front
Back

EMPLOYER Fill out this section for modified duty or time loss claims only

1) Rate of Pay ______ per mo/wk/hr 2) Days Worked per Week _________ 3) Hours per Week _________

4) Health Benefits (circle) Y or N 5) Monthly benefits (med/vision) paid $________ per mo/wk/hr

PART II TO BE COMPLETED BY EMPLOYEE

Employee statement of how incident occurred, and how it could have been avoided:

MEDICAL RELEASE AUTHORIZATION: I hereby authorize my physician, clinic, hospital, agency, HMO network or therapy provider to release to my employer's representative any medical records regarding current or previous treatment(s) that has been furnished to me.

Employee's Signature __________________________ Date ____________

Employer's Signature __________________________ Date ____________
RE: L&I Claim #__________

Dear ____________:

I am pleased to offer you employment with ____________ which will accommodate your current physical capacities. The job is that of ____________. This job is available on a reasonably continuous basis and additional modifications can be made based on objective medical findings and associated restrictions. The details of this offer are subject to all hiring and employment requirements and may include verification of employment eligibility and drug testing. A detailed description of the job which has been approved by a medical provider has been attached to this letter. The specifics of your employment include but are not limited to:

1) You will report for duty on ___/___/___ at the following address:


2) Your shift will begin at ___ and will end at ___. You will be scheduled for ___ (shift/hours) per week. This is based on your pattern of employment established prior to the date of your injury.

3) You will report to ______________, who will act as your direct supervisor, and he/she has been advised of your physical capacities.

4) Your wage will be $____ per hour and you will receive benefits in accordance with our company policy.

5) If you have additional medical appointments, you must schedule them outside of work hours unless approved by a supervisor, or scheduled by L&I.

6) As necessary, training will be provided to help satisfactorily complete assigned duties not previously performed.

7) Should you experience any difficulties in the performance of your duties; you are to report them to _______________(supervisor's name) as soon as possible.

8) This employment relationship is at-will which means both we as the employer and you as the employee are free to end this relationship at any time with or without cause.

Should you have any questions regarding this letter, please contact ____________ at ( ) - ______. Please contact me by telephone no later than ___/___/___ to accept or decline this job offer.

Please check the appropriate box below and return this letter to me, by hand, or post-marked no later than ___/___/___. If you do not contact me by ___/___/___ and/or you do not show up for work on ___/___/____ your time loss benefits will most likely end.

* I ACCEPT THIS OFFER

* I DECLINE THIS OFFER (may affect L&I time loss benefits)

Employee's Signature __________________________ Date __________

Sincerely,

Encl.: Approved Job Analysis
Cc: Claims Manager, ERNW, Vocational Counselor, Attending Doctor