**RETURN TO WORK / MODIFIED DUTY PROGRAM**

Purpose

The availability of modified duty, also referred to as light duty, will assist employees in returning to their regular work routine and limiting time off from work. This, in turn, will allow the employee the opportunity to maintain productive work habits while recovering from their injury.

Keep in mind, a modified duty job need not be at full hours, full wages and/or in the department or job the employee was working in when the injury occurred.

**Procedures**

Prior to an employee injury:

* The company Approved Physician or Authorized Treating Physician should be made aware that the company has a Modified Duty/Return to Work Program.

After an employee injury has occurred:

* Every effort will be made to provide modified duty to any and all injured employees who need modified duty to return to work.
* Management should remind both the approved treating physician and claim adjuster that modified duty will be made available.
* If the injured employee has difficulty in completing Modified Duty assignments, the claim adjuster handling the claim should be notified as soon as possible and the injured employee referred to the approved treating physician.

**Supporting Materials**

***[The following is a list of supporting materials, forms or attachments, which you may need to supplement your Return to Work Program].***

* Attachment **[number]** – Physician’s Release to Return to Work Form

**PHYSICIAN’S RELEASE TO RETURN TO WORK FORM**

|  |  |
| --- | --- |
| Employee’s Name:  | Date:  |
| Physician’s Name:  | Phone #:  |

**To be completed by Physician**

After reviewing the attached job description and the specific tasks within the job description please complete either (A) or (B) as appropriate and sign and date below.

1. The above named employee has been released by the above named physician to return to **Full Duty** as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Date) with **NO RESTRICTIONS**.

1. The above named employee has been released by the above named physician to Return to Work on \_\_\_\_\_\_\_\_\_\_\_(Date) **WITH THE FOLLOWING RESTRICTIONS** through \_\_\_\_\_\_\_\_\_\_(Date):

|  |
| --- |
| **Check applicable boxes and provide limitations/restrictions.** |
| * Lifting (Max weight in lbs) \_\_\_\_\_\_\_\_\_lbs.
 | * Walking \_\_\_\_\_\_\_\_\_\_\_ hours per day
 |
| * Repetitive Lifting \_\_\_\_\_\_\_\_\_\_\_lbs.
 | * Standing \_\_\_\_\_\_\_\_\_\_\_ hours per day
 |
| * Carrying \_\_\_\_\_\_\_\_\_\_\_\_\_lbs.
 | * Sitting \_\_\_\_\_\_\_\_\_\_\_ hours per day
 |
| * Pushing/Pulling \_\_\_\_\_\_\_\_\_\_\_lbs.
 | * Crawling \_\_\_\_\_\_\_\_\_\_\_ hours per day
 |
| * Pinching/Gripping \_\_\_\_\_\_\_\_\_\_\_lbs.
 | * Kneeling \_\_\_\_\_\_\_\_\_\_\_ hours per day
 |
| * Reaching overhead
 | * Squatting \_\_\_\_\_\_\_\_\_\_\_ hours per day
 |
| * Reaching away from body
 | * Climbing \_\_\_\_\_\_\_\_\_\_\_ hours per day
 |
| * Repetitive Motion Restrictions:

   |
| * Other Restrictions:

   |
|  |  |

|  |  |
| --- | --- |
| Physician’s Name (Please Print):  |   |
| Physician’s Signature:  |   | Date:  |   |

I AGREE THAT:

I will follow through with all of the restrictions listed above. I will notify my supervisor of any departure from these restrictions.

|  |  |  |  |
| --- | --- | --- | --- |
| Employee’s Signature:  |   | Date:  |   |