

A PRACTICAL GUIDE
FOR EMPLOYERS
AND EMPLOYEES

Return to Work

for small businesses



TexasMutual[®]
WORKERS' COMPENSATION INSURANCE
WORK SAFE, TEXAS[®]



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Make Your Return-to-Work Process Fit Your Company

At Texas Mutual Insurance Company, we work hard to help employers maintain a safe work place, but we know that no business is immune to on-the-job injuries. When an employee is injured on the job, your first responsibility is to get him or her prompt medical care. But don't stop there. Texas Mutual encourages employers to do their part to help injured employees get well and return to work.

What's in it for employers?

- ▶ Maintain production by keeping experienced workers on the job.
- ▶ Avoid paying overtime, finding temporary help, or hiring someone new. Studies show that the cost of replacing experienced workers can be twice their annual salary.
- ▶ Control workers' compensation claim costs.

What's in it for injured workers?

- ▶ Steer clear of the stress and depression that often come with being unable to work.
- ▶ Retain their job skills, company benefits, and seniority.
- ▶ Maintain their pre-injury income. Remember, workers' compensation benefits pay only a portion of the injured employee's salary.
- ▶ Avoid the disability mindset: "I'm injured, and I cannot work."

Developing a return-to-work process for a small business can be challenging. Often, the most difficult aspect is putting the process in writing. That's why Texas Mutual Insurance Company created this guide. You can easily adapt the examples on the following pages to fit your company's needs.

If you have questions, contact your Texas Mutual adjuster or safety services consultant. If you are preparing documents with legal implications, please consult your company's legal counsel.



Remember the Basics

A return-to-work process includes three key parts: assessing job tasks, identifying modified duties, and making a bona fide offer of employment.

Assessing job tasks

Write down the separate activities or tasks involved in each job at your company. Include the physical demands (such as lifting, typing, standing) and the environmental conditions (such as vibration, noise, heat) in your descriptions.

Identifying modified duties

Use your task list to match the available work to the injured employee's work restrictions, as sanctioned by his or her treating doctor. Always tell the employee's doctor about the modified duties to make sure they meet the doctor's restrictions.

Making a bona fide offer of employment

If you can offer an injured employee modified duties that meet his or her doctor's restrictions, put the offer in writing. Tell your Texas Mutual adjuster whether the injured employee accepts the offer. If an injured employee refuses a bona fide offer of employment, the employee may lose his or her temporary income benefits.

Put It in Writing

On the following pages, we've provided sample documents to assist you with your return-to-work process. The descriptions below explain how to use each one. If you have questions about the documents or how to use them, call your Texas Mutual adjuster or safety services consultant.

Policy statement

Write a policy statement that confirms your commitment to the return-to-work process and explains the return-to-work philosophy. Your policy statement should stress the importance of safe operations, immediate medical care after an injury, and returning an injured employee to work as soon as medically reasonable.

Employee responsibilities

Write procedures that explain the steps an injured employee will take from the time of injury until after the employee returns to work. Employees will understand the return-to-work process better and support it more fully if you include them in the development process.

Employee meeting sheet

Review the information on the policy statement, the procedures, and the medical contact information with all of your employees. Be sure all employees sign the sheet to document that they attended the meeting and understand the process.

Physical demands task assessment

Use this form to describe physical demands and environmental conditions for each job at your company. Identify modified assignments to bring injured employees back to work.



Letter to doctor

A letter of introduction will explain that your company is willing to work with the doctor, the employee and the insurance company to provide alternative productive work (modified duty) that will meet the employee’s work restrictions. Make arrangements with a doctor or clinic in your area for prompt medical care for your injured employees. If you have a Texas Mutual® policy that includes the Texas Star Network® program, your injured employee must receive care from a network treating doctor. Visit the Health Care Network page at texasmutual.com for a list of network providers.

Release for medical information

Have injured employees take a medical information release form with them to the doctor. The doctor and the injured employee may keep a copy of the signed form for their records, and your company can keep the original signed form in its return-to-work file.

DWC-73, Work Status Report

Use this form to get the injured employee’s medical restrictions as sanctioned by the treating doctor. NOTE: The Texas Department of Insurance, Division of Workers’ Compensation (DWC) requires doctors to provide this form to employers. Visit texasmutual.com/employerforms to access employer forms and sample documents, including the DWC-73 Work Status Report.

DWC-74, Description of Injured Employee’s Employment

Use this form to describe the injured employee’s job duties to the doctor. This information will help the doctor determine when the injured employee can return to work at full or modified duty. Visit texasmutual.com/employerforms to access employer forms and sample documents, including the DWC-74 Work Status Report.

Checklist for making a bona fide offer of employment

Make sure your offer meets DWC requirements. Use this checklist to verify that your offer complies with DWC rules.

Bona fide offer of employment letter

Send a bona fide offer of employment by certified mail to any injured employee who is able to return to work under doctor-sanctioned restrictions. If the injured employee does not speak or read English, contact your Texas Mutual adjuster. They will have the offer translated for you.

Modified duty work agreement

Have the employee and the employee’s supervisor (and return-to-work coordinator, if applicable) sign this form. The agreement states that the employer will not ask the injured employee to work outside of his or her medical restrictions.

Phone log

If an injured employee is physically unable to return to work, keep a phone log of all contact with the employee, the treating doctor, and any other involved party. Include the times and dates of all contacts and attempted contacts. Maintain contact with the employee regardless of how long they are off work.

Contact Texas Mutual Insurance Company

If you have questions about creating or updating a return-to-work process for your business, contact a Texas Mutual safety services consultant or adjuster.

Sample Policy Statement for the Return-to-Work Process

(Company name) is committed to providing a safe and healthy workplace for our employees. Preventing injuries and illnesses is our primary objective.

If an employee is injured, we will use our return-to-work process to provide assistance. We will get immediate, appropriate medical attention for employees who are injured on the job, and we will attempt to create opportunities for them to return to safe, productive work as soon as medically reasonable.

Our ultimate goal is to return injured employees to their original jobs. If an injured employee is unable to perform all the tasks of the original job, we will make every effort to provide alternative productive work that meets the injured employee's capabilities.

The support and participation of management and all employees are essential for the success of our return-to-work process.

President/CEO

Muestra de una Declaración Político del Proceso de Regreso al Trabajo

(Company name) se compromete a proporcionar un lugar de trabajo seguro y saludable para nuestros empleados. Nuestro objetivo principal es prevenir heridas y enfermedades.

Si un empleado se lastima, usaremos nuestro proceso de regreso al trabajo para proporcionar ayuda. Proporcionaremos atención médica apropiada inmediatamente para los empleados que se lastimen en el trabajo y crearemos oportunidades para que regresen a un trabajo seguro y productivo lo más pronto razonable.

Nuestra meta principal es regresar a los empleados lastimados a sus trabajos originales. Si un empleado es incapaz de realizar todas las tareas de su trabajo original, haremos todo lo posible por proporcionar un trabajo alternativo que vaya de acuerdo con las capacidades del empleado lastimado.

El apoyo y participación de la gerencia y de todos los empleados es esencial para el éxito de nuestro proceso de regreso al trabajo.

Presidente

Please photocopy this blank form.

Sample of Employee Responsibilities Regarding Work-Related Injuries

You are responsible for working safely and following all safety rules.

If you are hurt on the job, you must report the injury immediately to your supervisor and go to the doctor that day for treatment, if necessary. We require drug testing after each work-related injury or illness.

Management is responsible for providing a safe work environment and for providing a smooth transition back to work for any employee who has experienced a work-related illness or injury.

We will encourage anyone who is off work due to a work-related injury or illness to return to work as soon as medically reasonable. We will provide modified work tasks as necessary.

We will work together to set guidelines for modified duty according to the doctor's restrictions.

It is essential that contact be maintained in order to promote your return to work. We care about your health, well-being and future with the company.

Procedures to follow after an incident:

- ▶ Report all incidents immediately, no matter how minor
- ▶ Complete an accident report
- ▶ Provide correct information immediately so that the DWC-1 form may be completed and filed within 24 hours
- ▶ Inform the physician that there is alternative productive work available
- ▶ Report to work on the next scheduled shift after you have been released by the doctor (either regular duties, modified duties, or reduced time)
- ▶ Perform only the jobs described by the doctor and manager, according to the doctor's restrictions
- ▶ Contact your manager weekly to discuss your restrictions and other return-to-work opportunities
- ▶ Verify that we have your current phone number and address

Failure to follow these procedures will result in disciplinary action according to the policies and procedures in the employee manual.

I have read and I understand all of the above policies, and I acknowledge my responsibilities.

Employee Signature: _____

Date: _____

Please photocopy this blank form.

Introduction to The Return-to-Work Process

DATE: _____

TRAINER: _____

RETURN-TO-WORK PROCESS REVIEWED:

- Policy statement and benefits to the employees
- Procedures to follow after an injury
- Alternative productive work and bona fide offer of employment letter

EMPLOYEES IN ATTENDANCE

NAME/SIGNATURE

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

EMPLOYEES NOT IN ATTENDANCE

DATE OF TRAINING

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please photocopy this blank form.

Physical Demands Task Assessment

Task title: _____ Date: _____

Analyst: _____

Task duration (hours/day): _____

With breaks: Yes / No Overtime (avg. hours/week): _____

Task description: _____

Postures	Hours at one time	Total hours per day
Stand		
Sit		
Walk		
Drive		

Lift/carry	None 0%	Occasional 0-33%	Frequent 34-66%	Constant 67-100%	Height of lift	Distance of carry
1-10 lbs						
11-20 lbs						
21-50 lbs						
51-100 lbs						
100 lbs						

Actions, motions	None 0%	Occasional 0-33%	Frequent 34-66%	Constant 67-100%	Description
Pushing					
Pulling					
Climbing					
Balancing					
Bending					
Twisting					
Squatting					
Crawling					
Kneeling					
Reaching					
Handling					
Fingering					
Repetitive hand motion					
Repetitive foot motion					

Equipment used	None 0%	Occasional 0-33%	Frequent 34-66%	Constant 67-100%	Description
Tools					
Machinery					
Equipment					

Environmental conditions	None 0%	Occasional 0-33%	Frequent 34-66%	Constant 67-100%	Description
Vibration					
Noise					
Extreme heat					
Extreme cold					
Wet/humid					
Moving parts					
Chemicals					
Electricity					
Radiation					
Other					

Comments: _____

Letter for the Treating Doctor

Replace all information in italics

(Date of letter)

(Doctor's name)

(Doctor's address)

Dear *(Doctor's name)*:

(Company's name) has implemented a return-to-work process. This process is designed to return an injured employee to the workplace as soon as medically reasonable. The employees at *(Company's name)* are aware of our desire to provide alternative productive work in the event of an injury.

If one of our employees is unable to return to his/her original job, we will make every attempt to return this employee to modified duties. We will also ensure that this position meets with ALL medical restrictions that you prescribe. If necessary, we are willing to rearrange work schedules around diagnostic or treatment appointments.

Our company has identified job duties that may be suitable for a "return-to-work" situation. Please call me at *(company's telephone number)* if you have any questions about our return-to-work process or the alternative productive work available.

We would also appreciate updated information regarding the employee's status after each appointment. Thank you in advance for your participation in our efforts to return injured employees to a safe and productive workplace.

Sincerely,

(Company's representative)

(Title)

(Company name)

Medical Release of Information

Replace all information in italics

(Date of letter)

(Claimant Name)

(Claimant Street Address)

(Claimant City, State, zip)

Re: Claim No. _____; Request for the release of nonpublic personal information including personal health information.

Dear *(add name of claimant here)*,

(The Employer) is requesting release of your nonpublic personal information from the treating doctor to aid in the return-to-work process. This may include medical and other related information, as described in the attached authorization. The Employer is requesting your authorization to obtain this information.

Please read the attached authorization. It is valid for 24 months as written, but you may authorize the release of your nonpublic personal information for a lesser period of time on the authorization. Once you have signed this authorization, you may later revoke it at any time by writing to the Employer at the address below:

(address)

to the attention of *(name)*.

Please sign and return the attached authorization to my attention at

(address).

Signing and returning the authorization will assist the Employer in the return-to-work process. Thank you in advance for your help in obtaining this information.

Sincerely,

(Name of Requestor)

(Title of Requestor)

Authorization for Disclosure of Nonpublic Personal Information

Claimant Name: _____

Claim No.: _____

By signing below, I, _____, (*claimant*) authorize my healthcare provider, their agents, employees or representatives, to release to

(*“the Employer”*) for the return-to-work process, my medical records that include: physical therapy notes, information or medical opinions including diagnosis and prognosis, information on work status and activity restrictions, information regarding impairment and disability, and information regarding maximum medical improvement.

A copy or facsimile transmission (fax) of this Authorization is as valid as the original. This Authorization is effective on the date signed below and will remain in effect for 24 months after signing, unless otherwise specified below.

I also understand that I have the legal right to revoke this Authorization by writing to

(*the “Employer”*) at

(*address*),

Attn:

If the Employer or a disclosing entity has already acted in reliance on my Authorization, my revocation will not apply to that action or transaction.

The potential exists that a recipient of nonpublic personal information might re-disclose information used or disclosed pursuant to this Authorization, in which case medical and other privacy laws may no longer protect it.

With limited exceptions, treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned on obtaining an Authorization.

Signature of claimant or person legally authorized to act for claimant

Please describe authority to act on behalf of claimant _____

Date signed _____

Time authorization in effect _____ 24 months _____

Checklist for Making a Bona Fide Offer of Employment

To be bona fide, the offer must meet requirements set by the Texas Department of Insurance, Division of Workers' Compensation, in rule 129.6.

The Division established these requirements because making a bona fide offer of employment can affect an injured worker's income benefits. As an employer, extending a bona fide offer means giving your employee the opportunity to return to work. When deciding whether an offer is bona fide, the Division considers the following:

- ▶ Is the offer in writing?
- ▶ Is a copy of the most recent DWC-73 work status report attached?
- ▶ Does the offer specify the location at which the employee will be working, including the complete address?
- ▶ Does the offer state the wages the employee will be paid?
- ▶ Does the offer contain a description of the physical tasks and time requirements that the position entails?
- ▶ Is the work schedule similar to what the employee worked before the injury?
- ▶ Does the letter contain the statement "will only assign tasks consistent with the employee's physical abilities, knowledge, and skills"?
- ▶ Does the offer contain a statement that the employer "will provide training if necessary"?
- ▶ Is the offer at a location that is geographically accessible to the employee, including both the location of the work and the availability of transportation?
- ▶ Is the offer consistent with the doctor's certification of the employee's work abilities?
- ▶ Was the offer communicated to the employee in writing with all the above requirements included?
- ▶ Does the offer remain open for at least 7 days following the employee's receipt of the letter?
- ▶ Is the work status report (DWC-73) upon which the offer is based shown to be enclosed?

Once the letter is completed and has been reviewed by Texas Mutual, send the offer to the injured worker two ways by certified mail with return receipt requested and by regular mail. Additionally, please send a copy of the letter and mail receipt to the email address, mailing address or fax number listed below.

Email: claimdocs@texasmutual.com

Mail: Texas Mutual Insurance Company
PO Box 12029
Austin, TX 78711-2029

Fax: (512) 224-3889

Please photocopy this blank form.

Sample Bona Fide Offer of Employment

CERTIFIED MAIL

RETURN RECEIPT REQUESTED

Date

Injured Employee Address

City, State ZIP

Dear :

(Company's name) would like to offer you a temporary, modified-duty job assignment at the following location:

Company Name	
Street Address	
City, State, ZIP	

The schedule and wages per hour for this position are:

Monday		Wages per hour	
Tuesday		Wages per hour	
Wednesday		Wages per hour	
Thursday		Wages per hour	
Friday		Wages per hour	
Saturday		Wages per hour	
Sunday		Wages per hour	

The job duties meet the work restrictions sanctioned by doctor's name and date of report (see enclosed work status report).

Below is the job title, list of the job duties, maximum physical requirements, and time requirements for this temporary, modified-duty assignment.

Job Title	
Job Description (list the responsibilities of the job)	

Please photocopy this blank form.

Maximum Physical Requirements and Time Requirements (max hours per day)

Task	Time	Task	Time
Standing		Walking	
Sitting		Climbing stairs/ladders	
Kneeling/squatting		Grasping/squeezing	
Bending/stooping		Wrist flexion/extension	
Pushing/pulling		Reaching	
Twisting		Overhead reaching	
Keyboarding/mouse		Driving	
Lifting/carrying (include number of pounds)			
Additional duties			

While you are working in this modified-duty job assignment, we will only assign tasks that are consistent with your physical abilities, knowledge, skills, and work restrictions as sanctioned by (doctor's name/date). We will provide training if necessary. If you are asked to perform duties that you believe are not within your restrictions, please cease work immediately and contact your supervisor.

Please sign below either accepting or rejecting this offer and return it to our office by (month/day/year*). If we do not hear from you, we will assume you have rejected this offer. Rejection of this offer may affect your entitlement to or amount of temporary income benefits.

Employee's Signature - Accepting Offer Date

Employee's Signature - Rejecting Offer Date

Sincerely,

Name,
Title
Company

Enclosed: DWC-73, Work Status Report from (doctor's name/date)

Please photocopy this blank form.

Sample Job Description with Physical and Time Requirements

This position will entail these specific tasks in accordance with your modified duty restrictions:

- ▶ Med count and recording
 - ▶ Requires sitting and/or standing up to 3 hours per day
 - ▶ Requires grasping/squeezing and lifting of items less than 10 pounds
- ▶ Cooking and supervising cooking and clean up
 - ▶ Requires standing/walking up to 2 hours
 - ▶ Requires grasping/squeezing and lifting of items less than 10 pounds
 - ▶ Requires reaching between eye and thigh level
 - ▶ Other staff and/or clients will be available for tasks out of range of movement
- ▶ Running errands
 - ▶ Driving to transport individuals, which will require less than 1 hour sitting and walking
 - ▶ Picking up limited grocery/household items, requiring walking and sitting less than 1 hour
 - ▶ Grasping, squeezing, and lifting items less than 10 pounds. Bags will weigh less than 10 pounds
 - ▶ Reaching between eye and thigh level
- ▶ Completing paperwork and filing
 - ▶ Sitting and up to one hour and wrist flex
- ▶ Supervising clients attending to their personal hygiene
 - ▶ Standing and reaching at arm height less than one hour per day
- ▶ Light cleaning and supervising clients doing household chores
 - ▶ Dusting at level between neck and hip
 - ▶ Cleaning windows and sills between an area of neck height and hip height
- ▶ Client skill teaching
 - ▶ Requires sitting and standing up to 8 hours per day

Your job restrictions include the following:

- ▶ No bending/stooping
- ▶ No pushing/pulling
- ▶ No working at heights
- ▶ No overhead reaching
- ▶ No lifting/carrying over 10 pounds

Please photocopy this blank form.

Sample Modified Duty Work Agreement

Employee's name: _____ Department: _____

Employee's title: _____ Date: _____

My work duties are changed from _____ (date) until _____ (date).

I am assigned to modified work duties or limited duties. My new work duties are listed below.

The duties above have been described to my doctor. My doctor has signed Form DWC-73 stating that I may do these activities under the following medical restrictions.

I agree to do the above work duties and follow my doctor's medical restrictions. If I ignore my medical restrictions, I understand that my employer may take disciplinary action.

If a supervisor or anyone else asks me to do work assignments or activities that don't follow my medical restrictions, I must immediately report the situation to _____ (name of return-to-work coordinator), who will take action to correct the situation.

If I think my new work duties are causing discomfort or making my medical condition worse, I will report this immediately to _____ (name of return-to-work coordinator).

Employee signature: _____ Date: _____

Supervisor signature: _____ Date: _____

Return-to-work coordinator signature: _____ Date: _____

Please photocopy this blank form.

Muestra de un Acuerdo de Trabajo Alternativo

(Sample Modified Duty Work Agreement)

Nombre del empleado: _____ Departamento: _____

Puesto del empleado: _____ Fecha: _____

Mis deberes de trabajo han cambiado de _____ (fecha) al _____ (fecha).

Estoy asignado a los deberes de trabajo alternativos o limitados. Mis deberes de trabajo nuevos están listados en la parte inferior.

Los deberes descritos en la parte superior han sido explicados a mi doctor. Mi doctor ha firmado una Form DWC-73 estableciendo que yo puedo realizar estas actividades bajo las siguientes restricciones médicas.

Acepto los deberes de trabajo listados en la parte superior y seguir las restricciones del doctor. Si ignoro mis restricciones médicas, entiendo que la compañía para la que trabajo puede tomar acciones disciplinarias.

Si un supervisor o cualquier otra persona me pide que haga tareas o actividades que no cumplan con mis restricciones médicas, debo reportar la situación inmediatamente a _____ (nombre del coordinador del regreso al trabajo), quien corregirá la situación.

Si pienso que mis nuevos deberes de trabajo están causando incomodidad o están empeorando mi condición médica, lo reportaré inmediatamente a _____ (nombre del coordinador del regreso al trabajo).

Firma del empleado: _____ Fecha: _____

Firma del supervisor: _____ Fecha: _____

Firma del coordinador del regreso al trabajo: _____ Fecha: _____

Please photocopy this blank form.

After-Injury Telephone Report

Employee's name: _____ Home phone: _____

Employee's supervisor: _____ Date of injury: _____

Treating doctor: _____ Doctor's phone: _____

Has the employer discussed workers' compensation benefits with the employee? Yes / No

Has the employer discussed the return-to-work process with the employee? Yes / No

Log of Doctor's Appointments

Date: _____ Time: _____

Comments

Contacted by: _____

Date: _____ Time: _____

Comments

Contacted by: _____

Date: _____ Time: _____

Comments

Contacted by: _____

Photocopy this blank form.

After-Injury Telephone Report, cont. Supervisor's Telephone Log

Date: _____ Time: _____

Comments

Contacted by: _____

Date: _____ Time: _____

Comments

Contacted by: _____

Date: _____ Time: _____

Comments

Contacted by: _____

How to Contact Us

Main number

(800) 859-5995

Claim reporting

Online at texasmutual.com

Phone (800) TX-CLAIM (892-5246)

Fax (877) 404-7999

Claim information

(800) 859-5995

Safety services

844-WORKSAFE (967-5723)



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