Workers' Compensation 201 Return-To-Work

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Course Objectives

- Purpose of Return-to-Work (RTW) programs
- Who is responsible
- Why RTW is good business
- Guidelines to succeed
- Challenges and strategies

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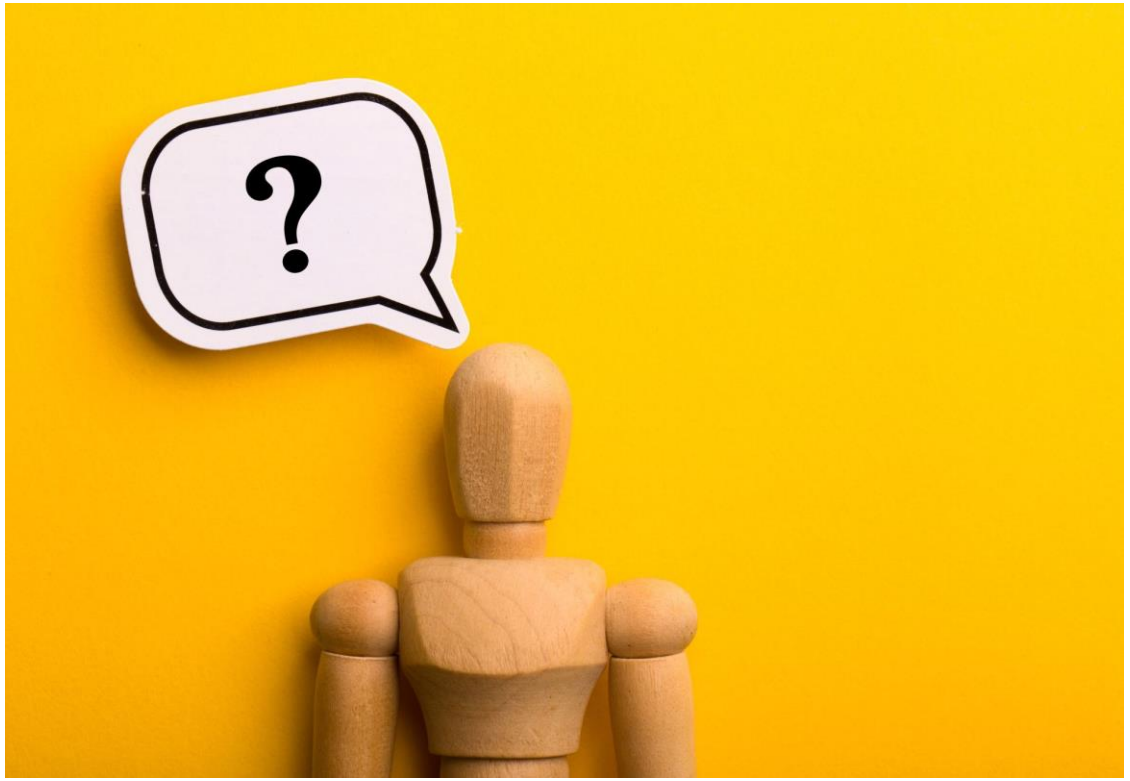
Now What?



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Medical Evaluation & Treatment

A treating doctor must be selected by injured worker

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DWC 73 - Work Status Report

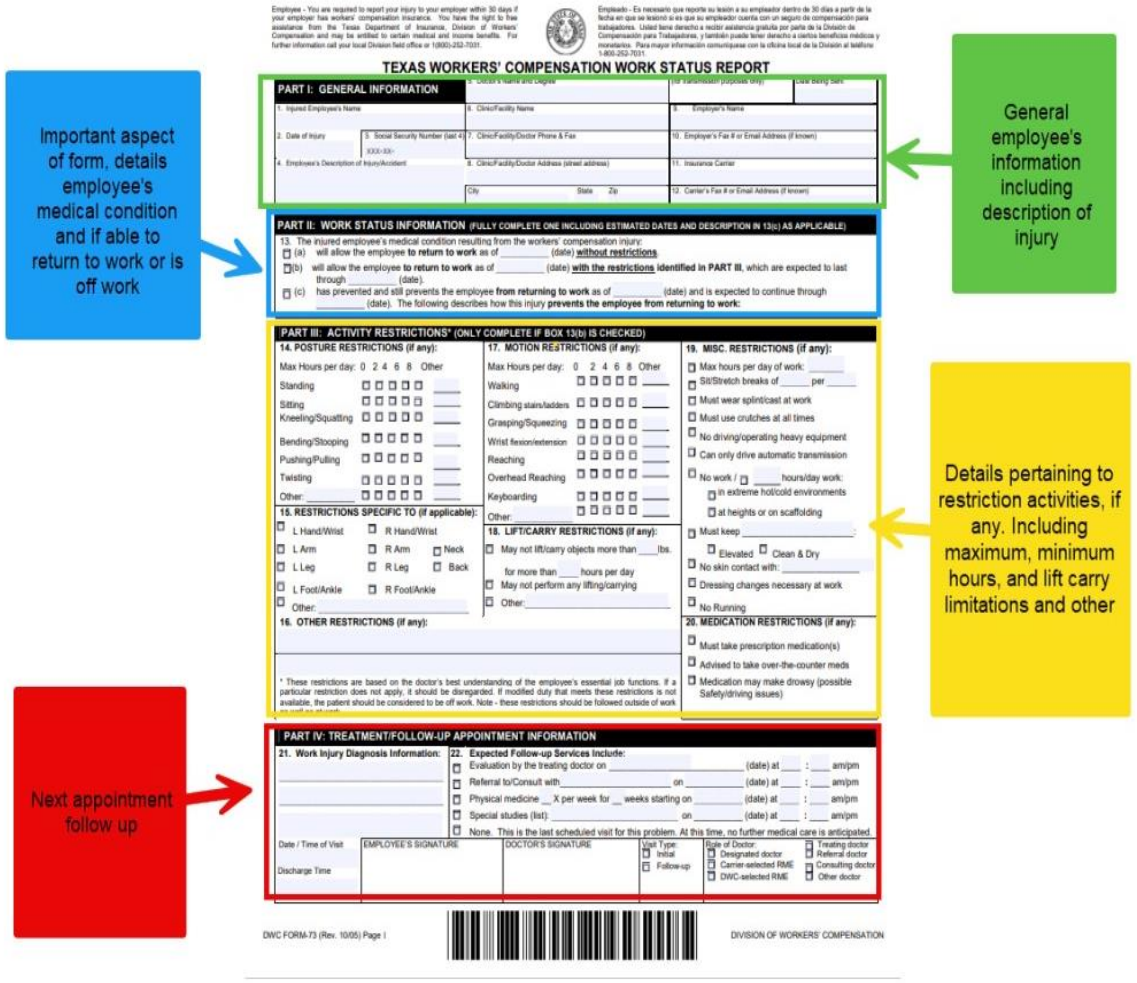
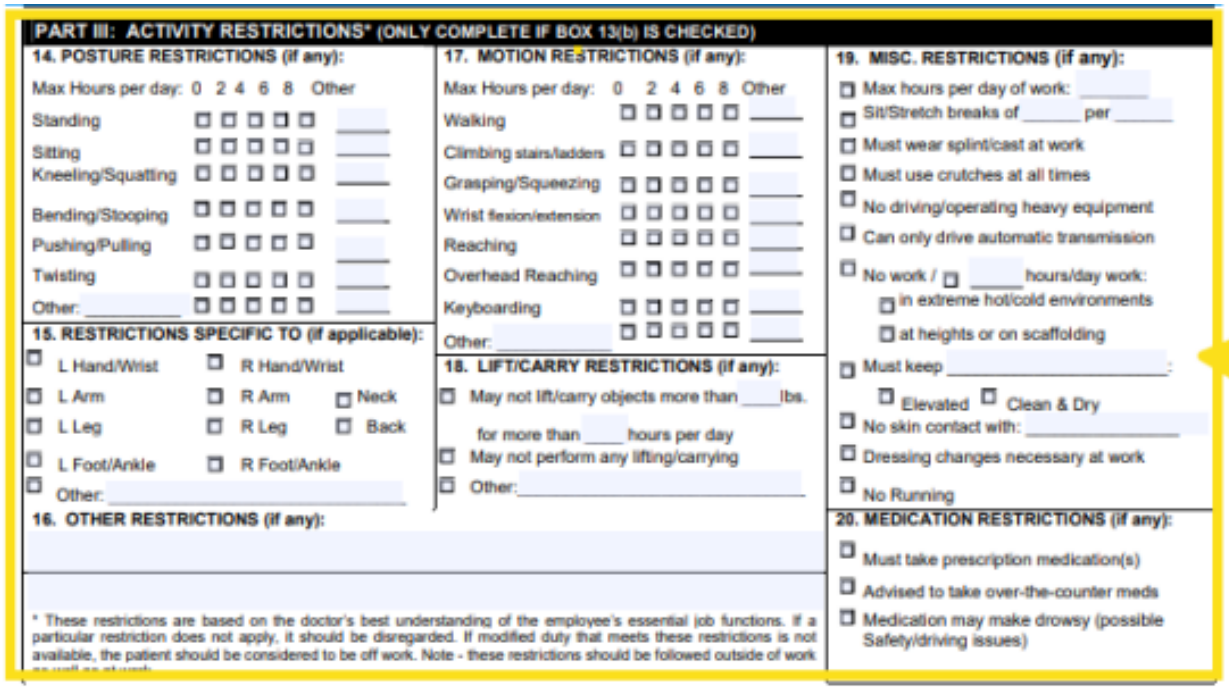


Image source: www.tdi.texas.gov/wc/index.html

DWC 73 - Work Status Report Modified Duty



PART III: ACTIVITY RESTRICTIONS* (ONLY COMPLETE IF BOX 13(b) IS CHECKED)

14. POSTURE RESTRICTIONS (if any):

Max Hours per day: 0 2 4 6 8 Other

Standing
Sitting
Kneeling/Squatting
Bending/Stooping
Pushing/Pulling
Twisting
Other: _____

15. RESTRICTIONS SPECIFIC TO (if applicable):

L Hand/Wrist R Hand/Wrist
L Arm R Arm Neck
L Leg R Leg Back
L Foot/Ankle R Foot/Ankle
Other: _____

16. OTHER RESTRICTIONS (if any):

17. MOTION RESTRICTIONS (if any):

Max Hours per day: 0 2 4 6 8 Other

Walking
Climbing stairs/ladders
Grasping/Squeezing
Wrist flexion/extension
Reaching
Overhead Reaching
Keyboarding
Other: _____

18. LIFT/CARRY RESTRICTIONS (if any):

May not lift/carry objects more than ____lbs.
for more than ____ hours per day
May not perform any lifting/carrying
Other: _____

19. MISC. RESTRICTIONS (if any):

Max hours per day of work: _____
Sit/Stretch breaks of _____ per _____
Must wear splint/cast at work
Must use crutches at all times
No driving/operating heavy equipment
Can only drive automatic transmission
No work / ____ hours/day work:
in extreme hot/cold environments
at heights or on scaffolding
Must keep _____:
Elevated Clean & Dry
No skin contact with: _____
Dressing changes necessary at work
No Running

20. MEDICATION RESTRICTIONS (if any):

Must take prescription medication(s)
Advised to take over-the-counter meds
Medication may make drowsy (possible Safety/driving issues)

* These restrictions are based on the doctor's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the patient should be considered to be off work. Note - these restrictions should be followed outside of work

Details pertaining to restriction activities, if any. Including maximum, minimum hours, and lift carry limitations and other

Image source: www.tdi.texas.gov/wc/index.html

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DWC 73 - Work Status Report Modified Duty

II. WORK STATUS INFORMATION (Fully complete one box including estimated dates, and a description in 13c, if applicable)

13. The injured employee's medical condition resulting from the workers' compensation injury:

☐ **a)** will allow the employee **to return to work** as of ____/____/____ **without restrictions**; **OR**

☐ **b)** will allow the employee **to return to work** as of ____/____/____ **with the restrictions identified in PART III**, which are expected to last through ____/____/____; **OR**

☐ **c)** has prevented and still prevents the employee **from returning to work** as of ____/____/____ and is expected to continue through ____/____/____.

The following describes how this injury **prevents the employee from returning to work:**

III. ACTIVITY RESTRICTIONS (Only complete if box 13b is checked)

14. Posture Restrictions (if any):

Max hours per day	0	2	4	6	8	Other:
Standing	☐	☐	☐	☐	☐	
Sitting	☐	☐	☐	☐	☐	
Kneeling/squatting	☐	☐	☐	☐	☐	
Bending/stooping	☐	☐	☐	☐	☐	
Pushing/pulling	☐	☐	☐	☐	☐	
Twisting	☐	☐	☐	☐	☐	
Other:						

15. Restrictions Specific To (if applicable):

☐ Left hand/wrist ☐ Left leg
☐ Right hand/wrist ☐ Right leg
☐ Left arm ☐ Back
☐ Right arm ☐ Left foot/ankle
☐ Neck ☐ Right foot/ankle
Other:

16. Other Restrictions (if any)

17. Motion Restrictions (if any):

Max hours per day	0	2	4	6	8	Other:
Walking	☐	☐	☐	☐	☐	
Climbing stairs/ladders	☐	☐	☐	☐	☐	
Grasping/squeezing	☐	☐	☐	☐	☐	
Wrist flexion/extension	☐	☐	☐	☐	☐	
Reaching	☐	☐	☐	☐	☐	
Overhead reaching	☐	☐	☐	☐	☐	
Keyboarding	☐	☐	☐	☐	☐	
Other:						

18. Lift/Carry Restrictions (if any):

☐ May not lift/carry objects more than ____ lbs. for more than ____ hours per day.
☐ May not perform any lifting/carrying.
Other:

19. Misc. Restrictions (if any):

☐ Max hours per day of work:
☐ Sit/stretch breaks of _____ per _____
☐ Must wear splint/cast at work
☐ Must use crutches at all times
☐ No driving/operating heavy equipment
☐ Can only drive automatic transmission
☐ No skin contact with:
☐ No running
☐ Dressing changes necessary at work

☐ No work /_____ hours/day work:
☐ in extreme hot/cold environments
☐ at heights or on scaffolding
☐ Must keep_____
☐ elevated ☐ clean & dry

20. Medication Restrictions (if any):

☐ Must take prescription medication(s)
☐ Advised to take over-the-counter meds
☐ Medication may make drowsy (possible safety/driving issues)

Is knowledge of your RTW efforts known?

Image source: www.tdi.texas.gov/wc/index.html

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Temporary Income Benefits (TIBS)

- 8th day of missed work
- Pays 70% of wages = earnings over $10.00
- Pays 75% of wages = earnings under $10.00

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Modified Duty

- Temporary accommodation
- Comply with restrictions
- Contribute to productivity

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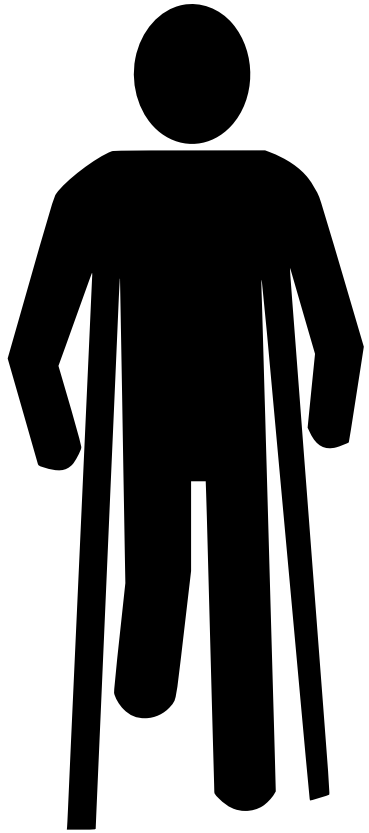
RTW Program

- Employer plan
- Temporary work
- Adheres to restrictions



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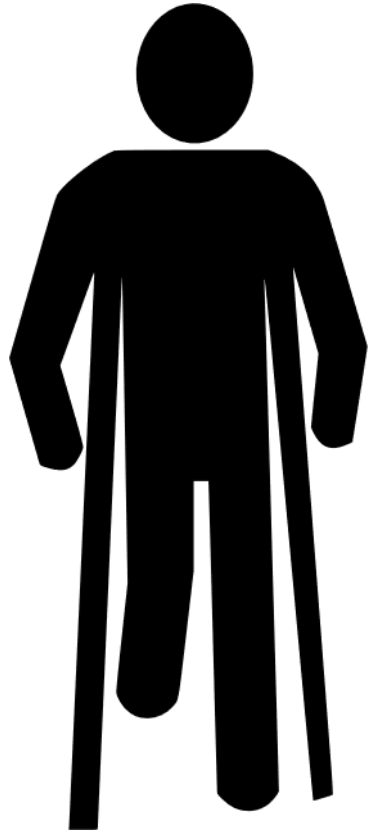
RTW Program

- Unique to your needs
- Consistent procedures
- Written policy



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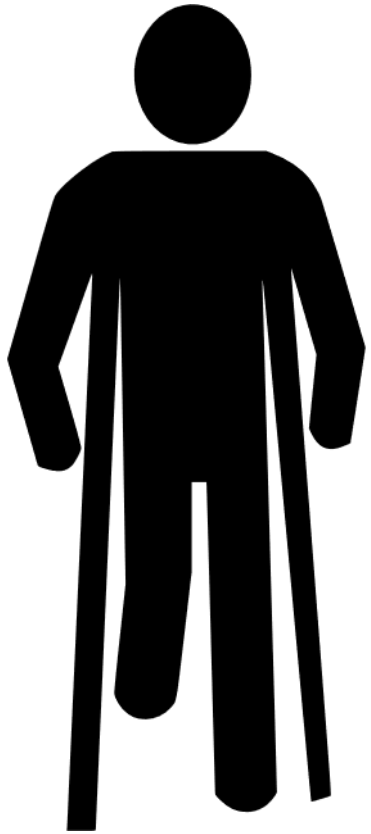
RTW Program



- Document & inform healthcare providers
- Routinely update adjuster
- Document & inform injured workers

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Making the Bona Fide Offer of Employment

Term “bona fide” refers to something that is genuine, valid, and made in good faith.

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Bona Fide Offer of Employment

- Must be in writing
- Template on employers' letterhead
- Executed in employee's familiar language
- **Must meet DWC Rule 129.6 requirements**

(Member Letterhead)

Date:

(Employee name and mailing address)

Dear:

We have been informed that Dr. _____ has released you to return to modified duty with restrictions as outlined in the **attached Work Status Report** dated _____. We are pleased to offer you the following temporary modified work assignment that we believe is within those restrictions.

To do this assignment, you will be required to:

1. **Description of the job**
2. **Physical requirements of the job: (Ex: lift 10 lbs. for 2 minutes twice a day)**
3. **List any break suggestions listed on the DWC-073**

You will be working at _____ campus located at: **(physical address)** and have the following work schedule **(include work schedule based on the employee's limitations):** _____ through _____ from _____ to _____. You will be paid **(list wages)** $ _____ per _____.

Please be assured that we are sympathetic to your injury, and **we will only assign tasks consistent with your physical abilities, limitations, job knowledge, and skills. We will provide any necessary training**.

The duration of this assignment will be _____ weeks. At the end of this period, we will review our needs to determine if an extension can be made, or if other suitable work is available.

This offer will remain **open for seven days from your receipt of this letter.** If we do not hear from you within seven days of receipt of this letter, we will assume you have refused this offer, which may impact your Temporary Income Benefits.

We are looking forward to your return. If you have any questions regarding this offer, please contact me at (xxx) xxx-xxxx.

Employee's Acknowledgement and Response

_____I have read this offer, understand the requirements of the position, and accept the position.

_____ I have read this offer, understand the requirements of the position, but decline the position.

_____ _____

Employee Signature Date

_____ _____

Employer (Signature, Title) Date

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TASB Risk Management Fund

Image source: www.tasbrmf.org

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DWC Rule 129.6 Requirements

- Has copy of DWC 73 attached
- Specify working location
- Specify work schedule
- Specify wages paid
- Description of physical and time requirements
- Statement regarding, “will only assign task consistent…”
- Statement regarding, “will provide training if necessary”
- Geographically accessible
- Job that is “consistent with the doctor’s certification of the employee’s work abilities”
- Offer open for 7 days following employee’s receipt

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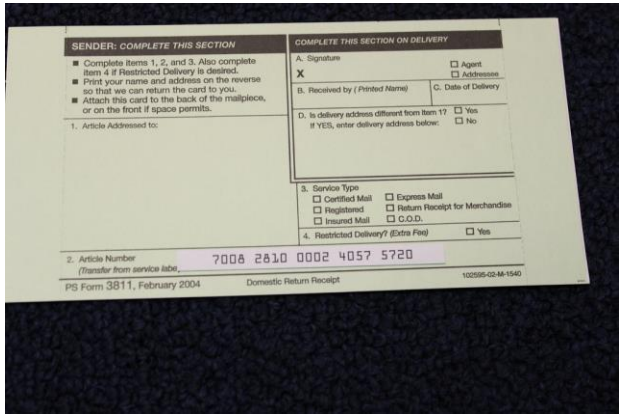
Bona Fide Offer of Employment

- Hand-deliver
- Mailed/return-receipt



BONA FIDE OFFER OF EMPLOYMENT

(Employer Letterhead)

Date:

(Employee name and mailing address)

Dear:

We have been informed that Dr. _____ has released you to return to modified duty with restrictions as outlined in the **attached Work Status Report** dated _____. We are pleased to offer you the following temporary modified work assignment that we believe is within those restrictions.

To do this assignment, you will be required to:

1. **Description of the job**
2. **Physical requirements of the job: (Ex: lift 10 lbs. for 2 minutes twice a day)**

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Misconceptions

An employer cannot talk to medical providers regarding RTW initiates

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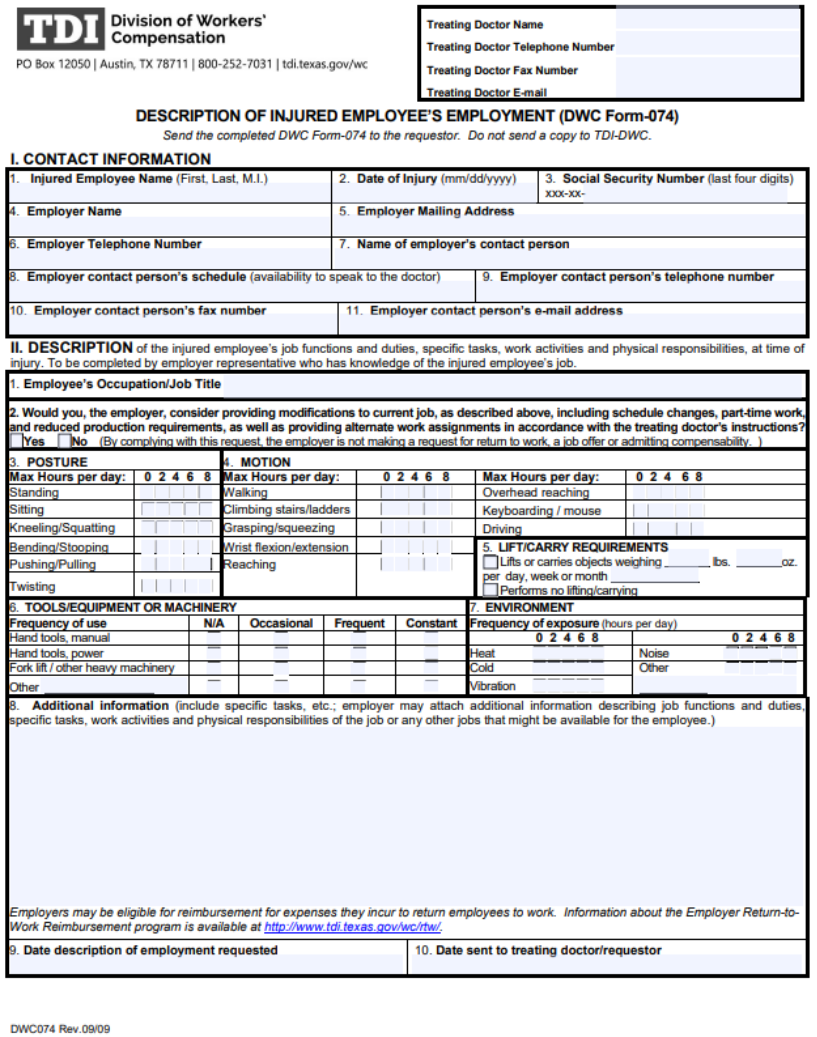
DWC 74 - Description of Injured Employee's Employment

Documents injured employee's job functions to a medical provider



TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Treating Doctor Name
Treating Doctor Telephone Number
Treating Doctor Fax Number
Treating Doctor E-mail

DESCRIPTION OF INJURED EMPLOYEE'S EMPLOYMENT (DWC Form-074)

Send the completed DWC Form-074 to the requestor. Do not send a copy to TDI-DWC.

I. CONTACT INFORMATION

1. Injured Employee Name (First, Last, M.I.)	2. Date of Injury (mm/dd/yyyy)	3. Social Security Number (last four digits) xxx-xx-
4. Employer Name	5. Employer Mailing Address	
6. Employer Telephone Number	7. Name of employer's contact person	
8. Employer contact person's schedule (availability to speak to the doctor)	9. Employer contact person's telephone number	
10. Employer contact person's fax number	11. Employer contact person's e-mail address	

II. DESCRIPTION of the injured employee's job functions and duties, specific tasks, work activities and physical responsibilities, at time of injury. To be completed by employer representative who has knowledge of the injured employee's job.

1. Employee's Occupation/Job Title

2. Would you, the employer, consider providing modifications to current job, as described above, including schedule changes, part-time work, and reduced production requirements, as well as providing alternate work assignments in accordance with the treating doctor's instructions?
☐ Yes ☐ No (By complying with this request, the employer is not making a request for return to work, a job offer or admitting compensability.)

3. POSTURE

Max Hours per day:	0 2 4 6 8
Standing	
Sitting	
Kneeling/Squatting	
Bending/Stooping	
Pushing/Pulling	
Twisting	

4. MOTION

Max Hours per day:	0 2 4 6 8
Walking	
Climbing stairs/ladders	
Grasping/squeezing	
Wrist flexion/extension	
Reaching	

Max Hours per day:	0 2 4 6 8
Overhead reaching	
Keyboarding / mouse	
Driving	

5. LIFT/CARRY REQUIREMENTS
☐ Lifts or carries objects weighing _____ lbs. _____oz. per day, week or month _____
☐ Performs no lifting/carrying

6. TOOLS/EQUIPMENT OR MACHINERY

Frequency of use	N/A	Occasional	Frequent	Constant
Hand tools, manual				
Hand tools, power				
Fork lift / other heavy machinery				
Other				

7. ENVIRONMENT

Frequency of exposure (hours per day)	0 2 4 6 8		0 2 4 6 8
Heat		Noise	
Cold		Other	
Vibration			

8. Additional information (include specific tasks, etc.; employer may attach additional information describing job functions and duties, specific tasks, work activities and physical responsibilities of the job or any other jobs that might be available for the employee.)

Employers may be eligible for reimbursement for expenses they incur to return employees to work. Information about the Employer Return-to-Work Reimbursement program is available at http://www.tdi.texas.gov/wc/rtw/.

9. Date description of employment requested	10. Date sent to treating doctor/requestor

DWC074 Rev.09/09

Image source: www.tdi.texas.gov/wc/index.html

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Job Descriptions

Before injury:

- Evaluates employee's pre-injury task ability

After injury:

- Modified job duties
- Aligns with restrictions

Sample Temporary Modified Duty Job Description

Address only the sections that need changes to comply with the physical restrictions and limitations outlined on DWC Form-73. All information on this form should match the Bona Fide Offer of Employment.

Job Title:	**Wage/Hour Status:**
Reports to:	**Pay Grade:**
Dept./School:	**Date Revised:**
Primary Purpose: Focus on outcome of the job rather than processes. Include expectations and special requirements.	

Qualifications:

Education/Certification: List required or desired licenses and certifications

Special Knowledge/Skills: List skill requirements

Experience: List required years of experience, training, and other qualifications

Responsibilities and Duties: List essential and marginal job duties. Be as specific as possible. Explain how frequently a task is performed and what equipment, tools, and materials are used.

Physical Demands: List the physical demands, including measurements, frequency, and duration. Describe body position, parts of the body used, and required exertion. Give number of hours per day spent performing each function. Describe temperature, hazards, and other conditions.

Supervisory Responsibilities

Equipment Used

Working Conditions: Mental and physical demands, as well as environmental factors

The statements above describe temporary modified duties in compliance with the physical restrictions and limitations outlined in the attached DWC Form-73 submitted by Dr. . The responsibilities assigned to this job are to be performed strictly as outlined and may not be amended without review and consent of the above-named treating physician.

Approved by Date

Reviewed by _____ Date _____

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TASB Risk Management Fund

Image source: www.tasbrmf.org

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Think Outside the Box

- Administrative work (inventory, data entry, filing, answering phones, keeping records, mail processing)
- Tutoring or mentoring to students
- Event planning (coordinate school events or activities)
- Safety efforts (assist in obtaining training aids, safety checks)
- Bus/hall monitor

Think Outside the Box

- Library assistance (book organization, check-ins/outs)
- Maintenance & custodial inventory

IMPORTANT: ALL INJURED EMPLOYEES ASSIGNED MODIFIED DUTY MUST RECEIVE APPROPRIATE TRAINING

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Challenges

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Buy In!

- Management is key
- Provide evidence
- Involve in planning
- Show leadership support

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Commitment Matters

Sample Statement of Management Commitment

_____ 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 or ill, we will get immediate medical attention and utilize our return-to-work program to create opportunities for the employee to return to productive as soon as medically possible.

Our goal is to return injured or sick employees to their original jobs. If a sick or injured employee is unable to perform all the tasks of the original job, we will make every effort to provide temporary modified work that meets the employee's medical restrictions.

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

_____

Superintendent

Image source: www.tasbrmf.org

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Analytics

RTW Savings = (Days RTW prior to PDD) x Average Weekly Wage (AWW)

Predicted Disability Duration (PDD)	Days RTW prior to PDD	Average Weekly Wage (AWW)	RTW Savings
85 Days	45 Days	$910	$5850

[/fusion_table]

RTW Savings = (Days RTW prior to PDD) X (AWW)

Bringing your employee back to work within 45 days before the Predicted Disability Duration, the employer avoided paying TD of $5,850. However, the savings does not stop there. You should also consider the **Hard and Soft savings**.

- Hard savings can include reduced use of pain medication or treatment costs
  - (Average savings 7-10%)
- Soft savings could be a lower number of treatments needed.
  - (Average savings 3-5%)

Image source: www.tasbrmf.org

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Analytics

If a worker is off work for 20 days, the chance of ever getting back to work is 70%

If the worker is off for 45 days, the chance of getting back to work is 50%

If the worker is off for 70 days, the chance of getting back to work is 35%

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Positive Reinforcement

- Show savings
- Great job!

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Incentive

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Overwhelming Response

"For an SAW/RTW program to be successful, it is imperative that the employer make a fundamental commitment to retaining/returning employees with an injury, illness, or disability to work in a timely and safe manner,"

-U.S. Department of Labor's Office of Disability Employment Policy (ODEP)

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Overwhelming Response

“Returning to work after an injury benefits both employees and their employers,”

-Texas Department of Insurance (TDI)

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It’s a Win-Win!

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Employees

- Heal faster
- Reduce finance losses
- Maintain their physical and emotional health

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Employers

- Benefit from productivity
- Claim cost savings
- Reduction in turnover/training costs

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Helpful Tips

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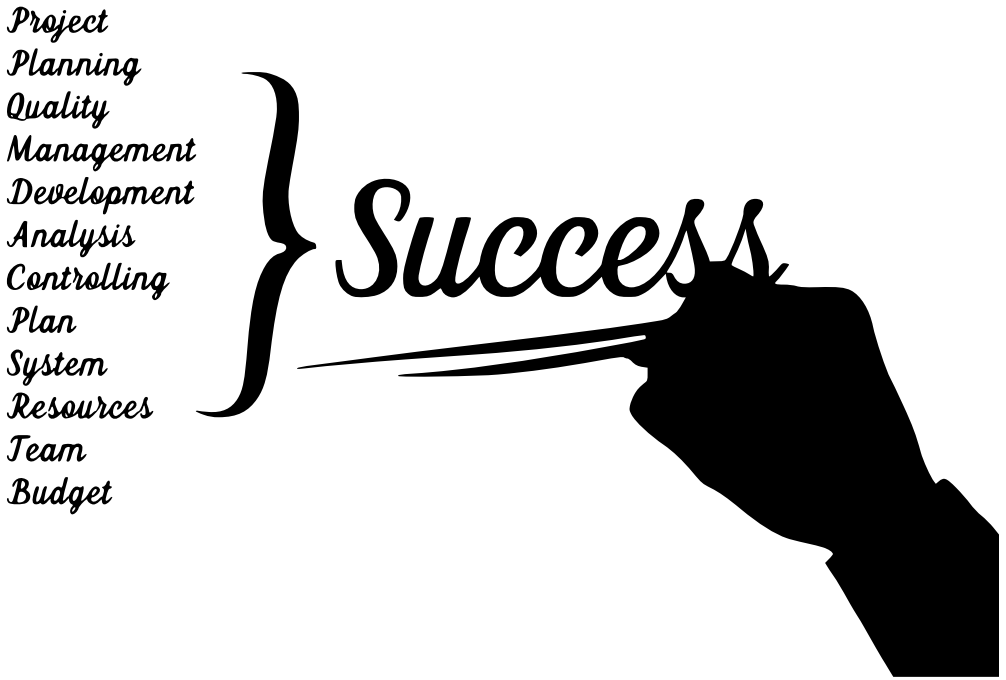
Prepare & Plan

- Policy
- Inform providers (medical/adjusters)
- Culture shift=create a RTW expectation
- Post-Injury job descriptions



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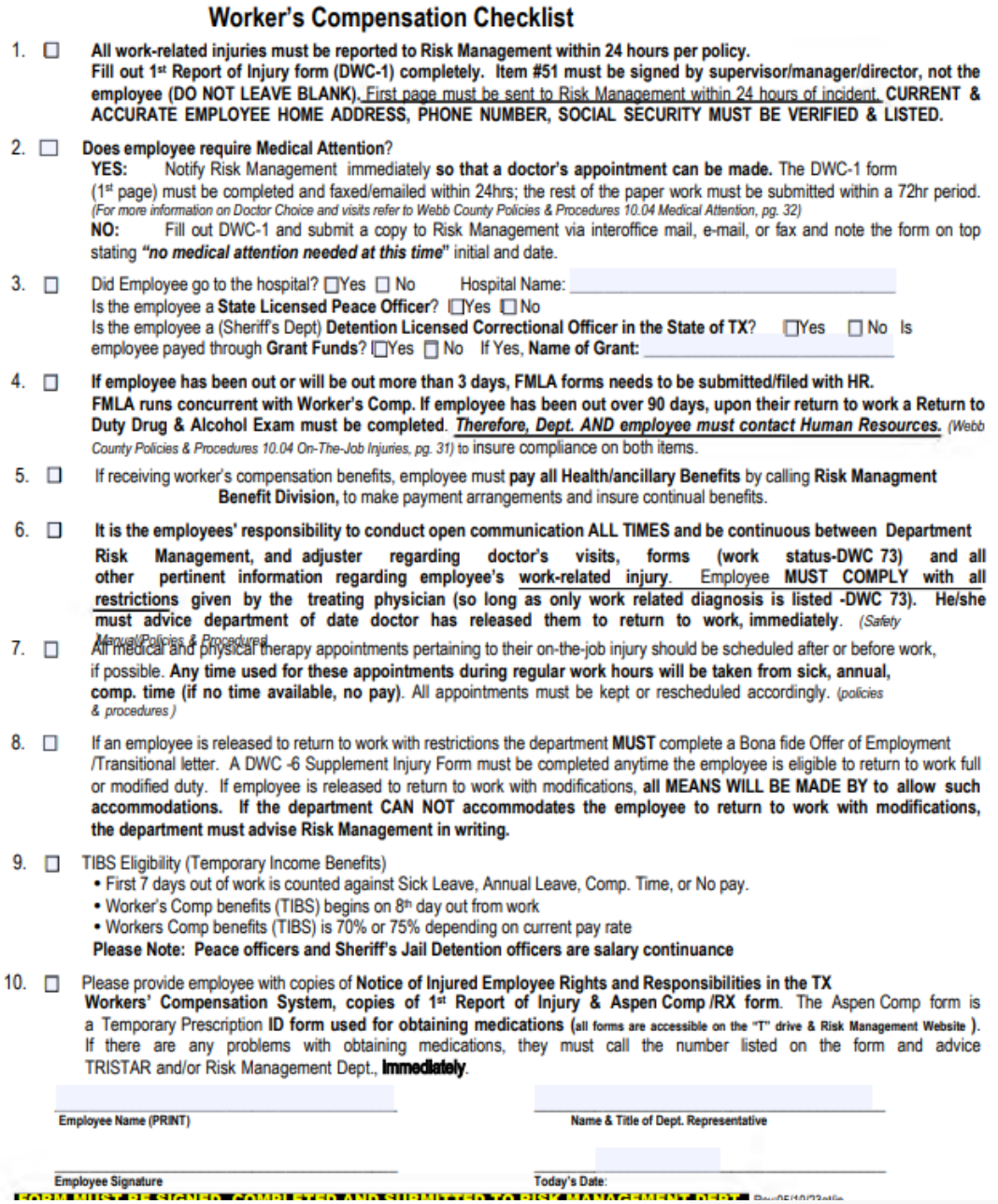
Injury Toolkit Checklist

Serves as a checklist for supervisors to streamline the internal claim process



Worker's Compensation Checklist

1. ☐ **All work-related injuries must be reported to Risk Management within 24 hours per policy.**
Fill out 1st Report of Injury form (DWC-1) completely. Item #51 must be signed by supervisor/manager/director, not the employee (DO NOT LEAVE BLANK). First page must be sent to Risk Management within 24 hours of incident. **CURRENT & ACCURATE EMPLOYEE HOME ADDRESS, PHONE NUMBER, SOCIAL SECURITY MUST BE VERIFIED & LISTED.**

2. ☐ **Does employee require Medical Attention?**
YES: Notify Risk Management immediately **so that a doctor's appointment can be made.** The DWC-1 form (1st page) must be completed and faxed/emailed within 24hrs; the rest of the paper work must be submitted within a 72hr period. *(For more information on Doctor Choice and visits refer to Webb County Policies & Procedures 10.04 Medical Attention, pg. 32)*
NO: Fill out DWC-1 and submit a copy to Risk Management via interoffice mail, e-mail, or fax and note the form on top stating ***"no medical attention needed at this time"*** initial and date.

3. ☐ Did Employee go to the hospital? ☐Yes ☐ No Hospital Name: _____
Is the employee a **State Licensed Peace Officer**? ☐Yes ☐ No
Is the employee a (Sheriff's Dept) **Detention Licensed Correctional Officer in the State of TX**? ☐Yes ☐ No Is employee payed through **Grant Funds**? ☐Yes ☐ No If Yes, **Name of Grant:** _____

4. ☐ **If employee has been out or will be out more than 3 days, FMLA forms needs to be submitted/filed with HR.**
FMLA runs concurrent with Worker's Comp. If employee has been out over 90 days, upon their return to work a Return to Duty Drug & Alcohol Exam must be completed. ***Therefore, Dept. AND employee must contact Human Resources.*** *(Webb County Policies & Procedures 10.04 On-The-Job Injuries, pg. 31)* to insure compliance on both items.

5. ☐ If receiving worker's compensation benefits, employee must **pay all Health/ancillary Benefits** by calling **Risk Managment Benefit Division,** to make payment arrangements and insure continual benefits.

6. ☐ **It is the employees' responsibility to conduct open communication ALL TIMES and be continuous between Department Risk Management, and adjuster regarding doctor's visits, forms (work status-DWC 73) and all other pertinent information regarding employee's work-related injury.** Employee **MUST COMPLY with all restrictions given by the treating physician (so long as only work related diagnosis is listed -DWC 73). He/she must advice department of date doctor has released them to return to work, immediately.** *(Safety Manual/Policies & Procedures)*

7. ☐ All medical and physical therapy appointments pertaining to their on-the-job injury should be scheduled after or before work, if possible. **Any time used for these appointments during regular work hours will be taken from sick, annual, comp. time (if no time available, no pay).** All appointments must be kept or rescheduled accordingly. *(policies & procedures)*

8. ☐ If an employee is released to return to work with restrictions the department **MUST** complete a Bona fide Offer of Employment /Transitional letter. A DWC -6 Supplement Injury Form must be completed anytime the employee is eligible to return to work full or modified duty. If employee is released to return to work with modifications, **all MEANS WILL BE MADE BY to allow such accommodations. If the department CAN NOT accommodates the employee to return to work with modifications, the department must advise Risk Management in writing.**

9. ☐ TIBS Eligibility (Temporary Income Benefits)
- First 7 days out of work is counted against Sick Leave, Annual Leave, Comp. Time, or No pay.
- Worker's Comp benefits (TIBS) begins on 8th day out from work
- Workers Comp benefits (TIBS) is 70% or 75% depending on current pay rate

Please Note: Peace officers and Sheriff's Jail Detention officers are salary continuance

10. ☐ Please provide employee with copies of **Notice of Injured Employee Rights and Responsibilities in the TX Workers' Compensation System, copies of 1st Report of Injury & Aspen Comp /RX form.** The Aspen Comp form is a Temporary Prescription **ID form used for obtaining medications (all forms are accessible on the "T" drive & Risk Management Website).** If there are any problems with obtaining medications, they must call the number listed on the form and advice TRISTAR and/or Risk Management Dept., **immediately**.

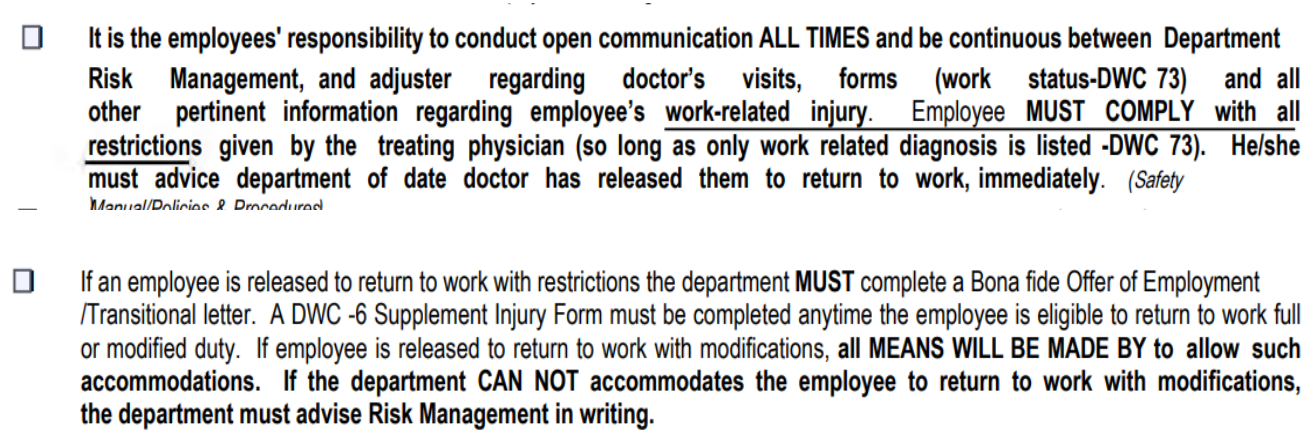
Employee Name (PRINT) _____ Name & Title of Dept. Representative _____

Employee Signature _____ Today's Date: _____

Image source: Texas County Risk Management Department

Injury Toolkit Checklist

Serves as a checklist for supervisors to streamline the internal claim process



- ☐ **It is the employees' responsibility to conduct open communication ALL TIMES and be continuous between Department Risk Management, and adjuster regarding doctor's visits, forms (work status-DWC 73) and all other pertinent information regarding employee's work-related injury.** Employee **MUST COMPLY with all restrictions given by the treating physician (so long as only work related diagnosis is listed -DWC 73). He/she must advice department of date doctor has released them to return to work, immediately.** *(Safety Manual/Policies & Procedures)*

- ☐ If an employee is released to return to work with restrictions the department **MUST** complete a Bona fide Offer of Employment /Transitional letter. A DWC -6 Supplement Injury Form must be completed anytime the employee is eligible to return to work full or modified duty. If employee is released to return to work with modifications, **all MEANS WILL BE MADE BY to allow such accommodations. If the department CAN NOT accommodates the employee to return to work with modifications, the department must advise Risk Management in writing.**

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Image source: Texas County Risk Management Department

Telemedicine

01

Under-utilized

02

Convenience

03

Efficiency

04

Accessibility

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Medical provider

- Non-compliant

Sample Letter to the Treating Doctor

(Date)

(Doctor's name)
(Doctor's address)

RE: Employee's Name

Dear Dr.

(Employee's name) is employed by (member name) as a (job title). (He or She) is under your care for an injury sustained on (date of injury).

(Member name) has a return-to-work (RTW) program designed to return injured employees to work safely and quickly. If (employee name) is unable to return to (his/her) original job, we will make every attempt to return (him/her) to a temporary modified duty assignment. We will also ensure that this position meets all medical restrictions you prescribe.

(Employee name) is aware of our desire to return (him/her) to the workplace. If necessary, we are willing to rearrange work schedules around diagnostic or treatment appointments.

Attached is (employee name's) current job description, including the position's physical demands. Please assist us by reviewing the job description and providing your recommendations for temporary modifications.

Please call me at (telephone number) if you have questions about our RTW program. Thank you in advance for helping (member name) return (employee's name) to a safe and productive workplace.

Sincerely,

(Employer representative)
(Title)
(Employer name)

Image source: https://www.tasbrmf.org

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Employee

Non-compliant

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Bridge the Communication

- Employer/Adjuster/Medical provider
- All play a role in a RTW program

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Monitor

MODIFIED-DUTY EMPLOYEES

EMPLOYEES OUT OF WORK

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Case Study I

An injured employee, working as a clerk, was involved in a vehicle collision. One of her restrictions was “no driving” due to an injury sustained in her leg. She was given a prescription for a motorized scooter.

Her employer offered her a BFOE (Bona Fide Offer of Employment). She stated that due to her restrictions, she could not drive to work. This was her 3rd injury claim. She lives approximately 7.3 miles from work.

What would you do?

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Case Study I

Explain to the employee that the job is ***sedentary,*** and it aligns with her restrictions. She can stand or walk for 2 hours (in accordance with restrictions). Therefore, she qualifies for the RTW program being offered to her. Furthermore, her wages (regular employee) and leave will not be impacted. She will resume her full pre-injury pay, while her medical needs (pertaining to the injury), including the scooter will be covered.

Case Study I

Transportation to work is a separate matter. The employer is not generally responsible for transportation. Will she need to make arrangements with public transport, ride share, or other means?

*The job offer is geographically accessible. Her restrictions might impede this job offer.

Is this a bona fide offer of employment?

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Important Note

Sedentary work is generally defined as a type of work that primarily involves sitting but may also involve some amount of walking and standing for brief periods of time.

Before assigning an injured employee to modified duties, verify the job description and functions with the medical provider and/or adjuster.

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Case Study II

Law enforcement official had multiple restrictions, such as taking 15-minute breaks every hour, standing, stretching, and walking around. Employee stated to doctor that her restrictions were not being followed. Adjuster was advised by doctor's concern and contacted employer. Employer contacted department. However, department assumed she was taking her breaks as needed and stretching.

What would you do?

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Case Study II

Employer contacted injured employee and stated concern for her well being and a speedy recovery. Therefore, proposed a conference call with the adjuster, department manager, and injured employee. Together, implemented procedures. Employee was to take at least four (4) 15-minute breaks a day and while she was away from her desk, post a note stating “On break, be right back” every time she needed to step away.

It could be less; it could be more. All agreed. This was documented in email and sent to the medical provider/adjuster.

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What’s Your Safety Culture?

- There, we got it!
- Almost there
- What’s a safety culture?

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Know Your Team

Name	Phone	E-mail	Regions
Ryan Boyce	800.482.7276, x2899	ryan.boyce@tasb.org	Regions 3, 4, 5, 6, and 7
Nicole Callahan	800.482.7276, x1136	nicole.callahan@tasb.org	Regions 7, 8, 10, 11, and 12
Javier Cano	956-324-1887	javier.cano@tasb.org	Regions 1, 2, 3, 15, and 20
Jesse Gonzales	800.482.7276, x2841	jesse.gonzales@tasb.org	Regions 9, 14, 16, 17, and 18
Charles Hueter	800.482.7276, x7184	charles.hueter@tasb.org	Regions 6, 12, 13, 15, 18, and 19





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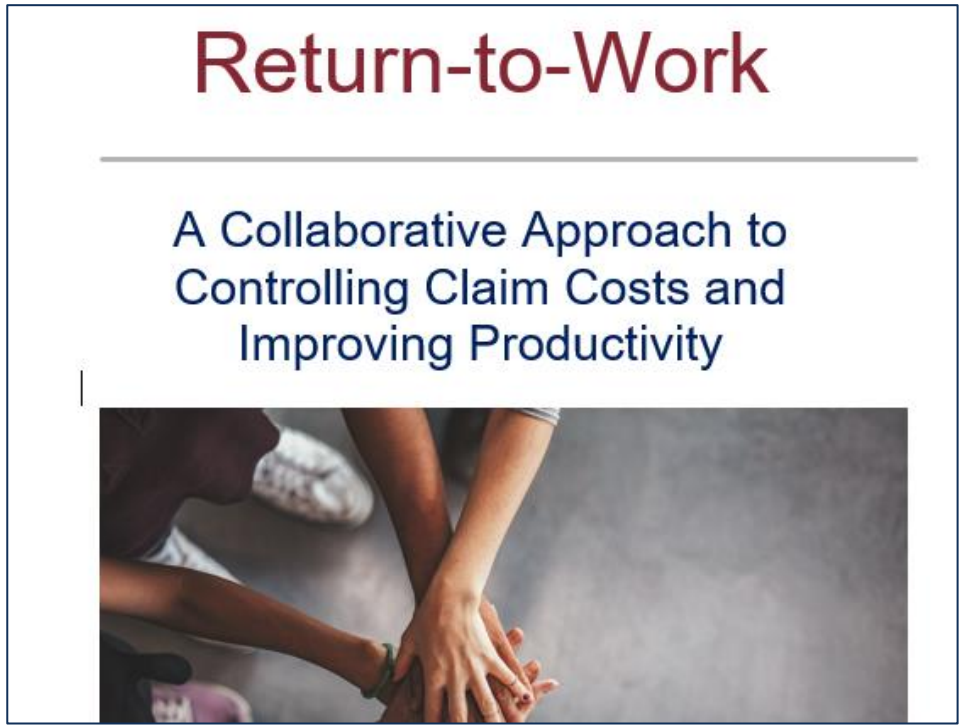
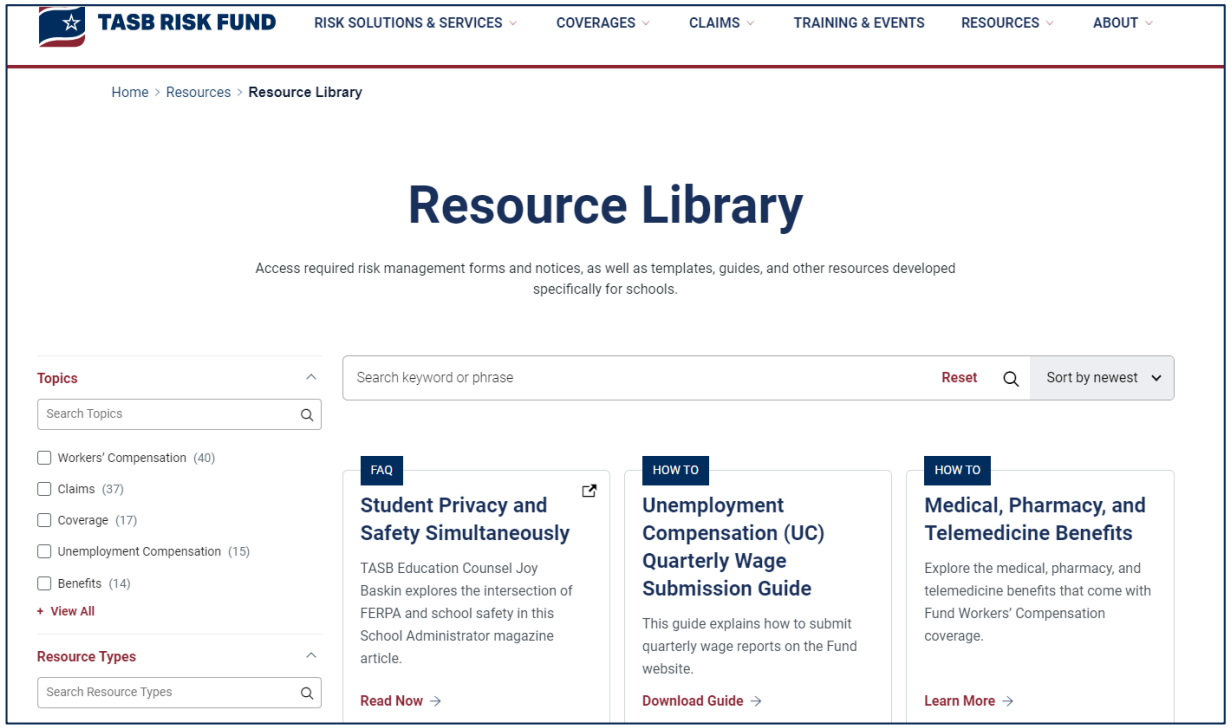
Recap

- Utilize the DWC-74 form
- Draft job descriptions
- Create your plan of action, policies, and checklists
- Have your BFOE document and a job bank ready
- Incorporate telemedicine
- Communicate with **all** stakeholders

Resources

tasbrmf.org/resources/resource-library





tasbrmf.org/resources/resource-library/return-to-work-guide

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Questions?

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Thank you!

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