



**RETURN TO WORK:  
JOBS SAVED AND  
CREATED!**



Sarita Shipe  
TASB Risk Management Compliance Coordinator



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**OBJECTIVES**

You will be able to determine your best course with respect to modified duty by understanding:

- Advantages of having a Return to Work Program
- The elements of an effective Return to Work Program
- Importance of a Functional Job Description
- Modified Duty Job Bank



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**BUT FIRST . . .**

Some things you didn't know about claims costs in Texas and why.



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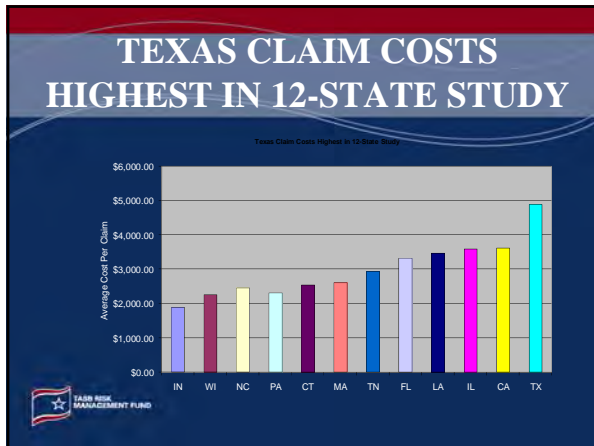
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### WHY ARE TEXAS COSTS HIGHER?

- ✓ Higher number of “lost time claims”
- ✓ Highest medical payments per claim for all health care providers and more visits per claim
- ✓ More medical and disability payments = more cost containment expenses

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### IN ADDITION . . .

More treatment leads to:

- Longer duration of TIBs
- Higher frequency of Impairment (60% of TX claims)
- Injured employees less likely to RTW

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**IS THERE AN ANTIDOTE TO ESCALATING COSTS?**

**IT'S YOU!**

The individual employer has the greatest opportunity to reduce losses in the WC system and to return the injured employee back to work.

**A SINGLE PHONE CALL IS ALL IT TAKES**



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**POLITICAL PRESSURE TO HAVE A PROGRAM**

**Texas Legislature Wants It (HB2600 in '01)**

- Employer required, upon written request, to notify employee, doctor, and carrier of availability of Return to Work
- Carrier required, with agreement of the employer, to provide RTW coordination service



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**POLITICAL PRESSURE TO HAVE A PROGRAM**

**Texas Legislature Wants It (HB7 in '05)**

- Networks/TASB Alliance
- Disability Management



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## ELEMENTS OF DISABILITY MANAGEMENT

- Treatment Guidelines – usual treatment anticipated for a specific injury per ODG. Example: Low back strain may be treated with PT up to 9 visits and over-the-counter anti-inflammatories.
- Treatment Planning - Medical treatment outside the ODG requires preauthorization.
- Return-to-Work Guidelines – Adopted MDA for the expected/average return to work time frames for specific types of injuries. Example: Anticipated return to work for a typical low back strain is within 0-3 days.



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## REASONS TO HAVE A PROGRAM

- Improved chances of returning employee to work sooner/employee assists in recovery
- Lost work days are decreased and claims resolved more quickly
- Retain employee's expertise
- Employee retains mental/physical work conditioning – “Wounded Worker”



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## “WOUNDED WORKER”

- > Employees' attitudes are affected by the reaction of supervisors/managers (that single phone call)
- > Focus on inabilities rather than abilities
- > Employee's self-perception can turn into a disabling condition; he defines himself by his impairment
- > Psychosocial issues set in motion
- > Prolonged “pain” – prolonged disability – prolonged treatment – unnecessary procedures eventually make the employee truly wounded.
- > A process is set up that enables the behavior that keeps them ill.



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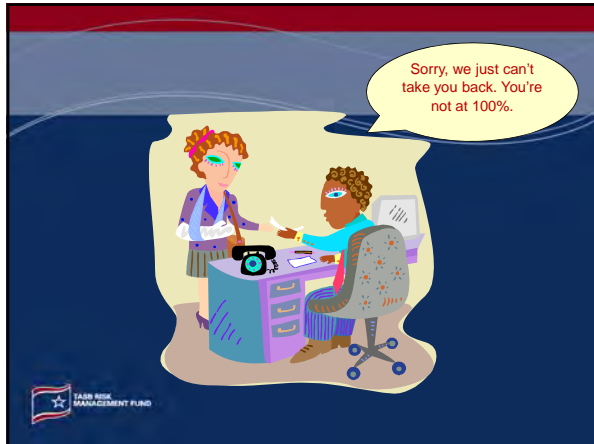
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### DISPEL THE MYTH!

“If I bring him back, he’ll get re-injured.”

- This situation is rare
- Symptoms are not harm
- Automatic assumption that time away from work after an injury is necessary
- Per treatment guidelines the **best treatment** is to return the employee to physical activity

This position is a **costly** mistake \$\$\$

TASB RISK MANAGEMENT FUND

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### OTHER REASONS TO HAVE A PROGRAM

- Uniform response to **all** work-related injuries
- Studies show early RTW with some symptoms does **not** increase risk of re-injury
- Actually reduces recurrences and sickness absences over the following year
- Reduction in overall claim costs up to **30-40%**

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TASB RISK MANAGEMENT FUND

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### Claims Costs **RTW** Districts

(Coppell ISD)

DOI Year	Avg TTL Cost	Avg/Claim	# of Claims
2000	\$630,409	\$5,210	121
2001	\$663,840	\$5,626	118
2002 (RTW)	\$215,571	\$2,795	77
2003	\$292,956	\$3,530	83
2004	\$67,567	\$1,266	53




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### Claims Costs **RTW** Districts

(Aldine's)

DOI Year	Avg TTL Cost	Avg/Claim	# of Claims
2004-05 (RTW)	\$2,207,411	\$2,920	756
2005-06	\$1,823,074	\$2,299	793
2006-07	\$1,978,505	\$2,620	755
2007-08	\$1,470,962	\$1,935	760




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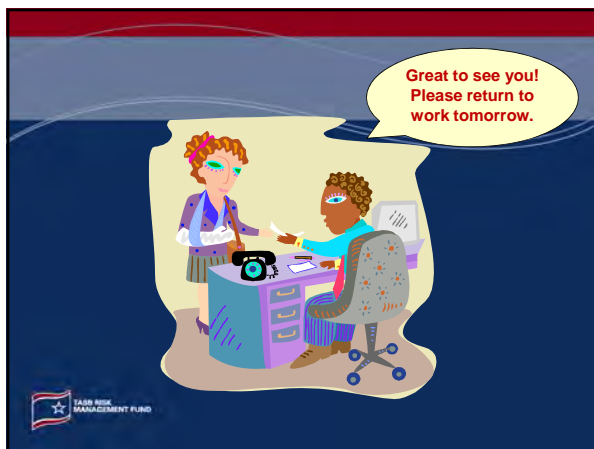
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### REASONS FOR UNNECESSARY TIME OFF WORK

According to physicians surveyed:

- Treating doc is unwilling to force a reluctant patient back to work (most common)
- Treating doc is not equipped to determine the right restrictions on work activity
- Employer has a policy against modified duty work
- Employer can't find a way to temporarily modify a job



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### REASONS FOR UNNECESSARY TIME OFF WORK

- Treating doc feels caught between the employer and the employee's version of events
- Treating doc has too little information about the physical demands of the job
- Conflict exists between two docs
- Employer wants to get rid of the employee



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### ELEMENTS OF RETURN TO WORK

**Management Commitment!**



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### OTHER ELEMENTS OF RETURN TO WORK

- Written procedures
  - Statement of responsibilities
  - Program coordinator
  - Known consequences for non-compliance with Bona Fide Offer
  - Member guidelines for maximum length of any modified position
  - Communication with adjuster/Loss Prevention




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### ISSUES IN IMPLEMENTATION

- Physicians - the unwillingness of employers to accept employees less than 100%
- You - knowing when doctor has given restricted RTW
- Identification of tasks
- Determining pay
  - Wages modified, insurance carrier pays difference
  - Full pre-injury wage




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### COMMUNICATE RTW BEFORE AN INJURY OCCURS

- ✓ Solicit employee/management buy-in
- ✓ Make sure employees know what to expect when injury occurs
- ✓ Create a Return to Work expectation
- ✓ Maintain contact with the off-work employee
- ✓ Clearly explain the purpose of modified **productive** work
- ✓ Consistent application

**\*Remember: A Return to Work assignment is only a temporary placement**




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### WHEN SHOULD THE DWC-73 BE FILED?

- The treating doctor must fax or send no later than **2 days** after the exam
  - Initial visit regardless of work status
  - Change in work status or restrictions
  - Request from insurance carrier
- Receipt of job description from employer or carrier
  - Report must be faxed or sent no later than **7 days** after receipt (See DWC-73 in handout)




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### IMPORTANCE OF A FUNCTIONAL JOB DESCRIPTION

- The treating doctor needs an accurate description of specific work activities to determine limitations
- Some injured employees may not always convey job duties as they really are
- Assists you in accommodating job tasks in line with doctor's restrictions.
- DWC-74 Form (in handout)




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### EXAMPLES OF MODIFIED DUTY

**Transportation**

- Bus Monitor/Aide
- Pumping fuel
- Perform filing and clerical tasks
- Parking lot Security


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**ANOTHER EXAMPLE**

**Food Service:**

- Serve as cashier
- Monitor lunchrooms
- Inventory food supplies and chemicals
- Perform filing and clerical tasks


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**MODIFIED DUTY JOB BANK**  
Chapter 2 – RTW Manual

- **Department** (sample in handout)
- **Type of Injury**
- **Tasks**
- **Describes Modified Responsibilities**
- **Your Input Requested - New Interactive Form**

[https://www.tasb.org/docs-mytab/risk\\_mgmt/wc\\_resources/publications/wcm/rtw/rtw\\_2009.pdf.cfm](https://www.tasb.org/docs-mytab/risk_mgmt/wc_resources/publications/wcm/rtw/rtw_2009.pdf.cfm)




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**ELEMENTS OF A BONA FIDE OFFER OF EMPLOYMENT**  
(DWC RULE 129.6)

- In writing
- Copy of DWC-73
- Location and schedule employee will work
- Wages to be paid
- Description of physical and time requirements
- Statement that only tasks consistent with abilities and knowledge will be assigned and training will be provided, if necessary

(Sample Letter in handout)




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### FILING THE DWC-6

- Must be filed with the carrier within **3 days** after return to full or modified duty
- If less wages earned, modified duty **amount paid (\$)** must be on DWC-6 (box 7)
- Every time there is a change in earnings or the employee elects paid leave, the **actual paid amount (\$)** and hours worked must be posted on the DWC-6




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### CALCULATING PAID LEAVE/TIB

Example:

AWW (DWC-3SD) =	\$800/week
Paid leave weekly wage =	\$750/week
Difference =	\$ 50
	x 70%
<b>TIB owed =</b>	<b>\$ 35</b>




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### PROCESS IN A NUTSHELL

- Employee reports an injury
- Direct the employee to prompt medical treatment
- Inform the doc that your district has a RTW program
  - Letter to the treating doctor
  - Functional job description (DWC-74)
  - Blank DWC-73


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### PROCESS IN A NUTSHELL

- Employee is released to work with restrictions
- Identify modified duty position
- Extend Bona Fide Offer of Employment
- Monitor employee at work for compliance with restrictions
- File DWC-6 for RTW or rejection of Bona Fide Offer



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### SUMMARY

Modified duty –

- Results in significant savings for your district
- Allows you to assist in your employees' recovery
- Is for a **temporary** disability
- Is a “Win-Win” for the employee and you!



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### MODEL PLANS AVAILABLE

- [http://www.tasb.org/services/risk/training\\_and\\_resources/fund\\_member\\_library/return\\_to\\_work.aspx](http://www.tasb.org/services/risk/training_and_resources/fund_member_library/return_to_work.aspx)
- <http://www.tdi.state.tx.us/wc/rtw/documents/rtwguide.pdf>



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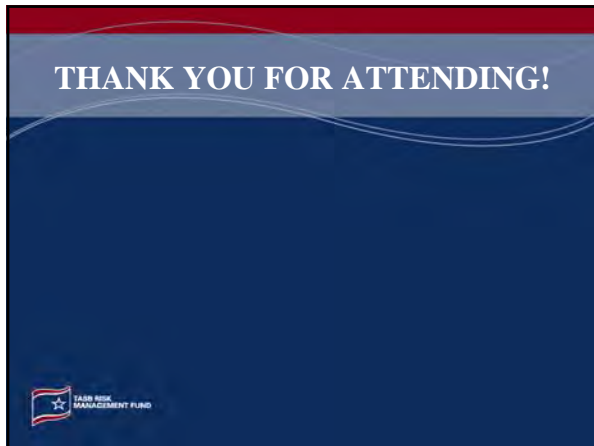
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Employee - You are required to report your injury to your employer within 30 days if your employer has workers' compensation insurance. You have the right to free assistance from the Texas Department of Insurance, Division of Workers' Compensation and may be entitled to certain medical and income benefits. For further information call your local Division field office or 1(800)-252-7031.



Empleado - Es necesario que reporte su lesión a su empleador dentro de 30 días a partir de la fecha en que se lesionó si es que su empleador cuenta con un seguro de compensación para trabajadores. Usted tiene derecho a recibir asistencia gratuita por parte de la División de Compensación para Trabajadores, y también puede tener derecho a ciertos beneficios médicos y monetarios. Para mayor información comuníquese con la oficina local de la División al teléfono 1-800-252-7031.

## TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

<b>PART I: GENERAL INFORMATION</b>			5. Doctor's Name and Degree _____ (for transmission purposes only)	Date Being Sent _____
1. Injured Employee's Name _____		6. Clinic/Facility Name _____		9. Employer's Name _____
2. Date of Injury _____	3. Social Security Number (last 4) _____ XXX-XX-	7. Clinic/Facility/Doctor Phone & Fax _____		10. Employer's Fax # or Email Address (if known) _____
4. Employee's Description of Injury/Accident _____		8. Clinic/Facility/Doctor Address (street address) _____ City _____ State _____ Zip _____		11. Insurance Carrier _____
				12. Carrier's Fax # or Email Address (if known) _____

### PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS 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 \_\_\_\_\_ (date) **without restrictions**.

(b) will allow the employee to **return to work** as of \_\_\_\_\_ (date) **with the restrictions identified in PART III**, which are expected to last through \_\_\_\_\_ (date).

(c) has prevented and still prevents the employee **from returning to work** as of \_\_\_\_\_ (date) and is expected to continue through \_\_\_\_\_ (date). The following describes how this injury **prevents the employee from returning to work**:

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

<p><b>14. POSTURE RESTRICTIONS (if any):</b></p> <p>Max Hours per day: 0 2 4 6 8 Other _____</p> <p>Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Kneeling/Squatting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Bending/Stooping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Pushing/Pulling <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Twisting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p>	<p><b>17. MOTION RESTRICTIONS (if any):</b></p> <p>Max Hours per day: 0 2 4 6 8 Other _____</p> <p>Walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Climbing stairs/ladders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Grasping/Squeezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Wrist flexion/extension <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Overhead Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Keyboarding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p> <p>Other: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____</p>	<p><b>19. MISC. RESTRICTIONS (if any):</b></p> <p><input type="checkbox"/> Max hours per day of work: _____</p> <p><input type="checkbox"/> Sit/Stretch breaks of _____ per _____</p> <p><input type="checkbox"/> Must wear splint/cast at work</p> <p><input type="checkbox"/> Must use crutches at all times</p> <p><input type="checkbox"/> No driving/operating heavy equipment</p> <p><input type="checkbox"/> Can only drive automatic transmission</p> <p><input type="checkbox"/> No work / <input type="checkbox"/> _____ hours/day work: <input type="checkbox"/> in extreme hot/cold environments <input type="checkbox"/> at heights or on scaffolding</p> <p><input type="checkbox"/> Must keep _____: <input type="checkbox"/> Elevated <input type="checkbox"/> Clean &amp; Dry</p> <p><input type="checkbox"/> No skin contact with: _____</p> <p><input type="checkbox"/> Dressing changes necessary at work</p> <p><input type="checkbox"/> No Running</p>
<p><b>15. RESTRICTIONS SPECIFIC TO (if applicable):</b></p> <p><input type="checkbox"/> L Hand/Wrist <input type="checkbox"/> R Hand/Wrist</p> <p><input type="checkbox"/> L Arm <input type="checkbox"/> R Arm <input type="checkbox"/> Neck</p> <p><input type="checkbox"/> L Leg <input type="checkbox"/> R Leg <input type="checkbox"/> Back</p> <p><input type="checkbox"/> L Foot/Ankle <input type="checkbox"/> R Foot/Ankle</p> <p><input type="checkbox"/> Other: _____</p>		<p><b>18. LIFT/CARRY RESTRICTIONS (if any):</b></p> <p><input type="checkbox"/> May not lift/carry objects more than _____ lbs. for more than _____ hours per day</p> <p><input type="checkbox"/> May not perform any lifting/carrying</p> <p><input type="checkbox"/> Other: _____</p>
<p><b>16. OTHER RESTRICTIONS (if any):</b></p> <p>_____</p> <p>_____</p> <p>_____</p>		<p><b>20. MEDICATION RESTRICTIONS (if any):</b></p> <p><input type="checkbox"/> Must take prescription medication(s)</p> <p><input type="checkbox"/> Advised to take over-the-counter meds</p> <p><input type="checkbox"/> Medication may make drowsy (possible Safety/driving issues)</p>

\* 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 as well as at work.

### PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

<p><b>21. Work Injury Diagnosis Information:</b></p> <p>_____</p> <p>_____</p>	<p><b>22. Expected Follow-up Services Include:</b></p> <p><input type="checkbox"/> Evaluation by the treating doctor on _____ (date) at _____ : _____ am/pm</p> <p><input type="checkbox"/> Referral to/Consult with _____ on _____ (date) at _____ : _____ am/pm</p> <p><input type="checkbox"/> Physical medicine ___ X per week for ___ weeks starting on _____ (date) at _____ : _____ am/pm</p> <p><input type="checkbox"/> Special studies (list): _____ on _____ (date) at _____ : _____ am/pm</p> <p><input type="checkbox"/> None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.</p>				
Date / Time of Visit _____	EMPLOYEE'S SIGNATURE _____	DOCTOR'S SIGNATURE _____	Visit Type: <input type="checkbox"/> Initial <input type="checkbox"/> Follow-up	Role of Doctor: <input type="checkbox"/> Designated doctor <input type="checkbox"/> Carrier-selected RME <input type="checkbox"/> DWC-selected RME	<input type="checkbox"/> Treating doctor <input type="checkbox"/> Referral doctor <input type="checkbox"/> Consulting doctor <input type="checkbox"/> Other doctor
Discharge Time _____					





# Texas Department Of Insurance

Division of Workers' Compensation  
7551 Metro Center Dr., Ste.100  
Austin, TX 78744-1609  
(512) 804-4000 (512) 804-4378 fax [www.tdi.state.tx.us](http://www.tdi.state.tx.us)

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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				4. MOTION				5. LIFT/CARRY REQUIREMENTS			
Max Hours per day: 0 2 4 6 8				Max Hours per day: 0 2 4 6 8				Max Hours per day: 0 2 4 6 8			
Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Walking <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Overhead reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Sitting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Climbing stairs/ladders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Keyboarding / mouse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Kneeling/Squatting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Grasping/squeezing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Driving <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
Bending/Stooping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Wrist flexion/extension <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				<input type="checkbox"/> Lifts or carries objects weighing _____ lbs. _____ x per day, week or month <input type="checkbox"/> Performs no lifting/carrying			
Pushing/Pulling <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				Reaching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>							
Twisting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
6. TOOLS/EQUIPMENT OR MACHINERY						7. ENVIRONMENT					
Frequency of use						Frequency of exposure (hours per day)					
N/A Occasional Frequent Constant						0 2 4 6 8 0 2 4 6 8					
Hand tools, manual <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						Heat <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					
Hand tools, power <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						Noise <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					
Fork lift / other heavy machinery <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						Cold <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					
Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					
Vibration <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
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 <a href="http://www.tdi.state.tx.us/wc/rtw/">http://www.tdi.state.tx.us/wc/rtw/</a> .											
9. Date description of employment requested						10. Date sent to treating doctor/requestor					

SAMPLE

## BONA FIDE OFFER OF EMPLOYMENT

(District 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 (describe physical and time requirements):

- 1.
- 2.
- 3.

You will be working at \_\_\_\_\_ campus and have the following work schedule: \_\_\_\_\_ through \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_. You will be paid \$ \_\_\_\_\_ per \_\_\_\_\_. Please be assured that we are sympathetic to your injury, and we will only assign tasks consistent with your physical abilities, knowledge and skills. Your supervisor will work with you to ensure that you receive the proper training necessary to do this work.

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

This offer will remain open for five days from your receipt of this letter. If we do not hear from you within five workdays, 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 ( ) - .

Sincerely,  
(Signature and Title)

I, \_\_\_\_\_, acknowledge receipt of this offer and accept/reject the provisions.

\_\_\_\_\_  
Date

# Modified Duty Job Bank Directory

**Department:** *Building Maintenance*

**Work Location:** *Maintenance Office*

**Job Title:**

**Work Hours:**

## Injury:

**Ankle/foot/leg injury** - (Slips, Trips, and Falls and contact with an object) Cannot stand or walk but by using a wheelchair, some modified duty can be performed; **or**, a task that could be done at a seated workstation for persons who can walk, but just can't stand for long periods of time.

### *Tasks*

### *Responsibilities*

1. Blade Sharpener	Sit and sharpen dull blades on blade sharpener.
2. Operate Parts Washer	Clean dirty tools with parts washer – recirculation of parts. Use safety glasses and gloves.
3. Salvaged Door Hardware	Sort salvaged door hardware and sort items to be reused.
4. Sorting of Parts Room	Sort shelves in parts room. Dust shelves and rearrange parts in order on shelf.
5. Shredding of Documents	Taking out the staples and shredding documents in the shredder as instructed by supervisor.
6. Grounds Keeper	Sit on stool outside and pull weeds. Hand pruning of shrubs and bushes

# Modified Duty Job Bank Directory

**Department:** *Building Maintenance*  
**Job Title:**

**Work Location:** *School and/or Maintenance Off.*  
**Work Hours:**

## Injury:

**Shoulder/Arm or Hand Injury** (Cuts, Burns, Sprains, and Strains) Listed below are tasks that require using one hand.

<i>Tasks</i>	<i>Responsibilities</i>
1. Shredding of Documents	Taking out the staples and shredding documents in the shredder as instructed by supervisor.
2. Grounds Keeper	Sit on stool outside and pull weeds. Hand pruning of shrubs and bushes with uninjured arm, shoulder, or hand.
3. General Cleaning	Cleans and wipes down break room. Sweep floor with a push broom.
4. Fire Extinguisher Inspection	Inspect all fire extinguishers in Maintenance Office to make sure they are not expired.
5. Supply Room	Sort and clean out bolts & screws that have gotten mixed together.
6. Blade Sharpener	Sit and sharpen dull blades on blade sharpener.
7. Operate Parts Washer	Clean dirty tools with parts washer – recirculation of parts. Use safety glasses and gloves.
8. Salvaged Door Hardware	Sort salvaged door hardware and sort items to be reused.
9. Sorting of Parts Room	Sort shelves in parts room. Dust shelves and rearrange parts in order on shelf.

