

Sample Industrial Insurance Claims Management Program

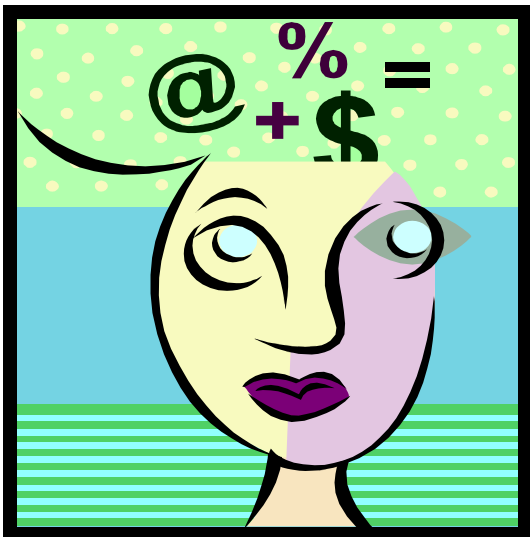
Your Company Name

Company Address

Company Address

Company Phone Number

(Revised 3/2006)



- *Please customize this program according to your company.*
- *Your written program can only be effective if it is put into practice!*

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Industrial Insurance Claims Management Program

Policy Statement:

Your Company Name values the safety, health and well being of all our employees. Our company policy is to provide safe and healthful working conditions in all operations and to follow the laws and regulations associated with the safety and health of our employees.

If you become injured on the job or in the course of your employment with Your Company Name and need medical attention, we will be directly involved with assisting you in getting what you need from the moment of your injury or illness. Your supervisor will take you, or assign a staff member to take you to the doctor or hospital; assist you with filing a company incident report; filing an Industrial Injury claim, if needed; and be involved in the subsequent accident investigation to identify and eliminate any hazards which may have been associated with your injury or illness. In the event of a claim, we will maintain close contact with you, your attending physician and the Department of Labor & Industries until your Industrial Insurance claim is closed.

Policy Objectives:

- To create a safe working environment in which work-related accidents and illnesses do not occur.
- To ensure that employees of Your Company Name who sustain work-related injuries receive the benefits they are entitled to under the Industrial Insurance laws.
- To return injured employees to full productivity and earnings as soon as it is medically feasible, and to maintain job security, while helping in the recovery process.
- We have developed restricted duty, modified duty and/or transitional duty work assignments for employees who are unable to return to their normal duties while recovering from their injuries (medical studies show that transitional return to work actually speeds the healing process). We will maintain close contact with your doctor to obtain specific information about the work you are able to perform during the recovery period from your injury in order to fully accommodate your return to work.

No one knows their jobs better than our employees do. Therefore, it is our expectation that when an employee experiences a work-related injury, that employee will fully participate in the recovery, rehabilitation and return to work process as a full partner in this effort.

As a condition of employment, I understand and agree to adhere to the above company policy. I also agree to report all injuries and unsafe or hazardous conditions to my supervisor immediately.

Employee's Name (PLEASE PRINT CLEARLY)

Employee's Signature

Date

**A copy of this policy can be signed by the employee on the date of hire and placed in the employee's personnel file along with the completed orientation checklist)*

President

Date

Vice President

Date

Secretary

Date

Executive Director

Date

Safety & Health Officer

Date

Company Claims Coordinator

Date

**Create signature lines with the names of the appropriate representatives of your company such as the owners, etc.*

Claims Management Procedure:

Steps to follow the 1st day of an injury or as soon as possible!

1. The employee's supervisor will go with or assign someone to take our injured employee to the doctor.
2. We will give the doctor a letter from our company, which states **Your Company Name's** intent to assist our employee in returning to work. **Along with the letter, we will include a job description of the job of injury. If possible, we will also provide a list of potential restricted, transitional, light or modified duty job descriptions available for RTW (Return to Work).**
3. At the time of initial medical treatment, we will get the claim number from the accident report form provided by the doctor's office that the employee and doctor both fill out at the time of the first doctor's visit. **We will need this claim number from here on out.**

If the employee for some reason has to go to the first doctor's appointment unaccompanied, it will be the employee's responsibility to call the employer immediately following the medical appointment to report the Industrial Insurance claim number assigned to his/her new claim.

4. **Your Company Name's** company claims coordinator will make an individual claim file to keep copies of all paperwork relating to the claim.
5. **The company claims coordinator will organize a "1st Day Packet" for L&I** to include the following items:
 - ✓ *Job description for job of injury (preferably signed by doctor, but send w/o signature if not available)*
 - ✓ *Employee's work history (i.e. copy of original job application)*
 - ✓ *Current payroll records (including cost of health/dental insurance premium)*
 - ✓ *Copy of company's internal incident report*
 - ✓ *Copy of company's Accident Investigation report, if available*
 - ✓ *New claim number will be written in large letters on the upper right corner of EACH PAGE of the above documentation*
6. The company claims coordinator will mail copies of each document listed above to:
Department of Labor & Industries, Insurance Services Division, P.O. Box 44299, Olympia, WA 98504-4299.

A copy of every page we send to L&I will be retained in our company's own working claim file for our employee.

7. If the doctor does not approve the job description, it will be **revised**, if possible, to better accommodate our employee's physical restrictions or consider an alternative job for our employee. The company claims coordinator will **resubmit the new job description** to the doctor. If needed, the company claims coordinator will send the doctor a "medical status" letter (sample herein) to get updated on our employee's medical condition in order to develop some type of medically suitable return to work plan for our employee. The company claims coordinator will keep our employee and their supervisor updated on the progress of the claim and return to work alternatives considered.
8. **The company claims coordinator will maintain regular contact with our injured employee** (every other day or at least once a week).
9. **THIS PROCESS WILL BE REPEATED** at least every two weeks until we determine whether or not our employee can return to the job of injury or needs further services. **We will keep the claim moving and be proactive at every opportunity!**
10. The (president, safety & health officer and the employee's supervisor or whoever the representatives for your company are) will investigate the accident within 24 hours of the incident to identify potential hazards and revise safety procedures if necessary.
11. **The company claims coordinator will send a formal job offer letter to our employee after the doctor approves return to work on any level** (letter templates contained herein).
12. **Management will review and improve our claims management program** and make changes we feel may be needed and/or appropriate to our company. This review process will take place on an annual basis on (September 1st or the date your company selects), or more often as needed.
13. The company claims coordinator will contact Becky Pierson (509-324-2546) or Al Conrad (509-324-2623) at the Dept. of Labor & Industries to discuss the claim and/or additional RTW options, if needed.

Modified Work Overview:

- Modified return to work following an Industrial Insurance injury is an important component of our Claims Management Program and is a priority to **Your Company Name**. The benefits of this program are rapid return to work for our employees and reduced Industrial Injury claim costs for the employee as well as the company as a whole.
- If for any reason you are unable to do your regular job because of a work-related accident or illness, we will require a release from your doctor for you to return to any type of work. We have a job description of your job of injury, which your doctor can use as a preliminary tool to release you back to work.
- On a regular, ongoing basis, our safety committee will collect and maintain lists of temporary jobs that any employee of the company could perform on a limited, transitional basis. We encourage all employees to participate in the process of identifying tasks that could be integrated into a temporary work assignment for injured employees recovering from an injury. If you notice work that needs to be done but seems get put on the shelf for a later time, please let a safety committee representative and/or your supervisor know about it. Additionally, if you have ideas about how you could do your regular job with temporary modifications, please talk to your immediate supervisor.
- Modified work begins the date the doctor releases you to it. Once your doctor has approved modified work, a meeting will be scheduled with you, your supervisor, and **Your Company Name's** company claims coordinator to outline the specific jobs you are released to do and the hours you will be able to work. A "Return to Work" agreement (samples contained herein) outlining the details of your modified work will be completed and signed by all parties. Modified work plans will last for two weeks and be re-assessed at two-week intervals to adjust your work duties as approved by your doctor. If you have any difficulties during this transitional work period, we encourage you to talk with your supervisor immediately. Our goal is to assist you in returning to your regular job as soon as your doctor deems it medically suitable for you.

We consider our employees to be our most valuable asset at Your Company Name. We will do everything possible to assist you in your return to your regular work activities.

Management Responsibilities:

For purposes of definition and clarity, “Management” representatives include the President, Vice President, Secretary, Executive Director and Safety & Health Officer (*or whoever this is specifically for your company*) for **Your Company Name**. The following management responsibilities apply specifically to those individuals occupying the above-designated positions:

- As a top company priority, management is committed to, supports, and enforces a strong safety program and through action, words and role modeling, maintains a company culture of **safety first**.
- At least one member of the management team will meet personally with all new employees during their orientation to reinforce the company’s Claims Management Program and the company’s commitment to **safety first**.
- Management will discuss the importance of maintaining a good safety record with employees at least once per year as a part of each employee’s annual evaluation. Management will educate employees on the cost of claims and the affect of lost workdays due to work-related accidents and illnesses associated with the previous work year.
- Management will meet with the company safety committee at least once every six months to participate in the management of and to keep abreast of the safety and health issues associated with the company and its employees. Management will be available to distribute incentive awards and to congratulate all employees on safe behavior in the workplace.
- Management will support and enable supervisors, the company claims coordinator and injured employees to take the action required to fulfill and program steps developed and to assist in a positive manner with the return to work process.

Supervisor Responsibilities:

- Supervisors will act as the communication link between management and injured employees.
- Supervisors will encourage and support all their employees to think and act safely on the job and to participate on the safety committee and all activities involving safety. In addition, on a daily basis, supervisors will communicate with all their respective employees regarding their responsibility to keeping themselves and their co-workers safe.
- Supervisors will report near misses, incidents not resulting in injury, and incidents resulting in injury/illness with or without a claim filed by completing the company's internal incident report. Supervisors will encourage and support their respective employees to do the same.
- In the event of a work-related accident/injury, supervisors are responsible for taking their injured employees to the medical provider of their choice. If for some reason a supervisor is unable to do this, the supervisor is responsible for assigning someone to take the employee to the doctor/hospital.
- The supervisor or their designee is responsible for assisting the injured employee with completing the accident report provided at the doctor's office/hospital, and obtaining the claim number to report back to the company claims coordinator.
- Supervisors are expected to be thoroughly informed regarding their employee's medical condition following a work-related injury/illness, and are expected to be knowledgeable about their employee's medical status throughout the recovery process. Supervisors will work collaboratively with the employee and **Your Company's Name** company claims coordinator to identify and coordinate the details of the employee's return to work on a modified or transitional basis until such time that the employee is medically able to return to their job of injury and restored to regular duty as it was prior to the injury. **The supervisor will meet with the employee prior to the beginning of their restricted duty assignment and complete a "Job Assignment Agreement" or "Return to Work" agreement (templates contained herein) in order to further clarify and understand the responsibilities of the employee and the supervisor during this temporary work assignment, and so that all parties understand the importance of the employee adhering to the medical restrictions.**
- In collaboration with the company president, safety & health officer, supervisors will participate actively in the accident investigation process for any incidents involving their direct reports.
- Supervisors will work in concert with their direct reports and the company safety committee to identify temporary work assignments that could result in good opportunities for modified return to work.

Company Claims Coordinator Responsibilities:

- **Your Company Name's** company claims coordinator is responsible for ensuring injured employees are provided with the following documents prior to leaving the work-site for medical treatment, in order that this information can be provided to the treating doctor at the initial medical visit following a work-related injury:
 - A copy of a job description for their job of injury
 - A letter to the doctor (“Dear Doctor” letter—samples contained herein) from **Your Company's Name**, indicating the company's intent to assist our employee with return to work based on what is considered medically suitable according to the attending doctor
 - A list of temporary, light duty job tasks that are available and could be considered for transitional return to work upon approval from the attending physician.
 - The company claims coordinator will make an individual claim file for each separate claim number in order to keep copies of all paperwork relating to that claim in one file. This will be done immediately upon notification of a work-related injury.
14. On the day of an injury, the company claims coordinator will organize a **“1st Day Packet”** for L&I to include the following items:
- ✓ *Job description for job of injury (preferably signed by doctor, but send w/o signature if not available)*
 - ✓ *Employee's work history (i.e. copy of original job application)*
 - ✓ *Current payroll records (including cost of health/dental insurance premium)*
 - ✓ *Copy of company's internal incident report*
 - ✓ *Copy of company's Accident Investigation report, if available*
 - ✓ *New claim number will be written in large letters on the upper right corner of EACH PAGE of the above documentation*
15. The company claims coordinator will mail copies of each document listed above to:
Department of Labor & Industries, Insurance Services Division, P.O. Box 44299, Olympia, WA 98504-4299.
16. If the attending doctor does not approve the job description for the job of injury, it will be revised by the company claims coordinator to better accommodate our employee's physical restrictions or consider an alternative job for our employee. The company claims coordinator will discuss other possible return to work alternatives with the employee and their supervisor. Based on what is negotiated in this discussion, the company claims coordinator will resubmit a new job description to the doctor for review and approval, reflecting the accommodations needed.

17. **Once the doctor approves a job description for our employee's return to work**, whether on a transitional, modified or full duty basis, **it is the responsibility of the company claims coordinator to provide the employee with a formal job offer letter (template contained herein)**, designed to confirm the details of the return to work arrangement.
18. The company claims coordinator will send **the doctor a medical status letter (template included) to obtain ongoing, updated information concerning the injured employee's medical condition and return to work status**. This will be done as often as needed as determined by the discretion of the company claims coordinator, but no less than once per month.
19. The company claims coordinator will be held accountable for maintaining regular contact with our injured employee either by checking in with that person by phone if at home, or in person if at work. Regular contact would be defined as once a week beginning on the day of injury and continuing throughout the claim process until medical and return to work issues have been resolved.
20. Once it appears that the medical and return to work issues have been resolved, it is the responsibility of the company claims coordinator to receive confirmation of this in writing from the doctor, and to send a closure letter (template included) to the claim manager at the Department of Labor & Industries, requesting that the claim be closed.

Safety Committee Responsibilities:

- Our Safety Committee is responsible for ensuring that all employees of **Your Company Name** work safely and for maintaining a safe and health work environment.
- In addition to the usual functions of our safety committee, the committee is tasked with collecting and maintaining job lists containing a description of specific work tasks that can be made available for modified duty work when needed. The committee is responsible for updating these job lists on a monthly basis, or as needed, for immediate work assignments.
- The safety committee chairperson is responsible for reporting to the safety committee all jobs that have been identified for modified work each month. The safety committee chairperson is also responsible for checking with each supervisor on a monthly basis to collect ideas that have been submitted by employees of the company.

Employee Responsibilities:

- **All work-related injuries must be reported immediately to supervisors** whether or not medical attention or wage replacement options are involved.
- An internal company incident report will be provided to injured employees and must be completed as soon as possible following an accident/illness and returned to the supervisor. The company will then conduct an accident investigation in order to identify and correct any existing safety and health hazards resulting.
- If an injured employee should experience problems with their recovery, be dissatisfied with medical treatment providers, or need help understanding the industrial insurance system, **Company Claims Coordinator's Name** for **Your Company's Name** is available to provide written information, assistance and/or support.
- Injured employees are asked to honor management requests to seek second opinions prior to surgery or when treatment does not appear to be effective.
- Employees are expected to fully participate in the process of identifying and/or developing appropriate return to work options that are considered to be medically suitable by the employee's attending doctor.
- Employees are expected to accept temporary, modified, transitional, or light duty work once the specified duties have been approved by their attending doctor.

Incident Report Form

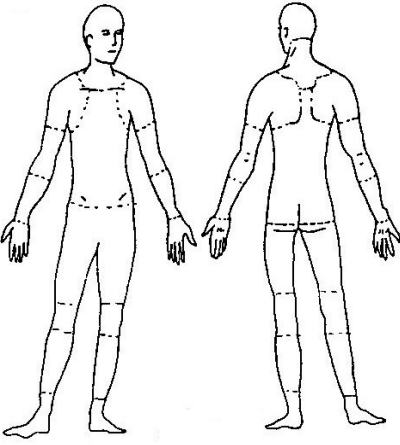
Instructions: *Employees* of **Your Company Name** may use this form to report all work related injuries, illnesses, or “near miss” events (which could have caused an injury or illness) – ***no matter how minor***. This helps us to identify and correct hazards before they cause serious injuries. This form should be completed by employees as soon as possible and given to a supervisor for further action.

I am reporting a work related: <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Near miss	
Your Name:	
Job title:	
Supervisor:	
Have you told your supervisor about this injury/near miss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of injury/near miss:	Time of injury/near miss:
Names of witnesses (if any):	
Where, exactly, did it happen?	
What were you doing at the time?	
Describe step by step what led up to the injury/near miss. (continue on the back if necessary):	
What could have been done to prevent this injury/near miss?	
What parts of your body were injured? If a near miss, how could you have been hurt?	
Did you see a doctor about this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, whom did you see?	Doctor's phone number:
Date:	Time:
Has this part of your body been injured before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, when?	Employer:
Your signature (optional):	Date:

Accident Investigation Report

Instructions: *Supervisors must complete this form as soon as possible after an incident that results in an injury, illness or property loss.*

This is a report of a: <input type="checkbox"/> Death <input type="checkbox"/> Lost Time <input type="checkbox"/> Dr. Visit Only <input type="checkbox"/> First Aid Only <input type="checkbox"/> Near Miss	
Date of incident:	This report is made by: <input type="checkbox"/> Supervisor <input type="checkbox"/> Team <input type="checkbox"/> Other

Step 1: Injured employee (complete this part for each injured employee)					
Name:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:			
Department:	Job title at time of incident:				
Part of body affected: (shade all that apply) 	Nature of injury: (most serious one) <input type="checkbox"/> Abrasion, scrapes <input type="checkbox"/> Amputation <input type="checkbox"/> Broken bone <input type="checkbox"/> Bruise <input type="checkbox"/> Burn (heat) <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Concussion (to the head) <input type="checkbox"/> Crushing Injury <input type="checkbox"/> Cut, laceration, puncture <input type="checkbox"/> Hernia <input type="checkbox"/> Illness <input type="checkbox"/> Sprain, strain <input type="checkbox"/> Damage to a body system: <input type="checkbox"/> Other _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">This employee works: <input type="checkbox"/> Regular full time <input type="checkbox"/> Regular part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary</td> </tr> <tr> <td style="padding: 5px;">Months with this employer</td> </tr> <tr> <td style="padding: 5px;">Months doing this job:</td> </tr> </table> <p style="text-align: right; font-size: small;">(e.g.: nervous, respiratory, or circulatory systems)</p>	This employee works: <input type="checkbox"/> Regular full time <input type="checkbox"/> Regular part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary	Months with this employer	Months doing this job:
This employee works: <input type="checkbox"/> Regular full time <input type="checkbox"/> Regular part time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary					
Months with this employer					
Months doing this job:					

Step 2: Describe the incident	
Exact location of the incident:	Exact time:
What part of employee's workday? <input type="checkbox"/> Entering or leaving work <input type="checkbox"/> Doing normal work activities <input type="checkbox"/> During meal period <input type="checkbox"/> During break <input type="checkbox"/> Working overtime <input type="checkbox"/> Other	
Names of witnesses (if any):	

Number of attachments:	Written witness statements:	Photographs:	Maps / drawings:
What personal protective equipment was being used (if any)?			
Describe, step-by-step the events that led up to the injury. Include names of any machines, parts, objects, tools, materials and other important details.			
Description continued on attached sheets: <input type="checkbox"/>			

Step 3: Why did the incident happen?	
Unsafe workplace conditions: (Check all that apply) <input type="checkbox"/> Inadequate guard <input type="checkbox"/> Unguarded hazard <input type="checkbox"/> Safety device is defective <input type="checkbox"/> Tool or equipment defective <input type="checkbox"/> Workstation layout is hazardous <input type="checkbox"/> Unsafe lighting <input type="checkbox"/> Unsafe ventilation <input type="checkbox"/> Lack of needed personal protective equipment <input type="checkbox"/> Lack of appropriate equipment / tools <input type="checkbox"/> Unsafe clothing <input type="checkbox"/> No training or insufficient training <input type="checkbox"/> Other: _____	Unsafe acts by people: (Check all that apply) <input type="checkbox"/> Operating without permission <input type="checkbox"/> Operating at unsafe speed <input type="checkbox"/> Servicing equipment that has power to it <input type="checkbox"/> Making a safety device inoperative <input type="checkbox"/> Using defective equipment <input type="checkbox"/> Using equipment in an unapproved way <input type="checkbox"/> Unsafe lifting by hand <input type="checkbox"/> Taking an unsafe position or posture <input type="checkbox"/> Distraction, teasing, horseplay <input type="checkbox"/> Failure to wear personal protective equipment <input type="checkbox"/> Failure to use the available equipment / tools <input type="checkbox"/> Other: _____
Why did the unsafe conditions exist?	
Why did the unsafe acts occur?	
Is there a reward (such as “the job can be done more quickly”, or “the product is less likely to be damaged”) that may have encouraged the unsafe conditions or acts? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:	
Were the unsafe acts or conditions reported prior to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have there been similar incidents or near misses prior to this one? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Step 4: How can future incidents be prevented?

What changes do you suggest to prevent this incident/near miss from happening again?

- Stop this activity Guard the hazard Train the employee(s) Train the supervisor(s)
- Redesign task steps Redesign work station Write a new policy/rule Enforce existing policy
- Routinely inspect for the hazard Personal Protective Equipment Other: _____

What should be (or has been) done to carry out the suggestion(s) checked above?

Description continued on attached sheets:

Step 5: Who completed and reviewed this form? (Please Print)

Written by:

Title:

Department:

Date:

Names of investigation team members:

Reviewed by:

Title:

Date:

JOB DESCRIPTION

(This format can be used to outline employee's regular job as well as modified duty jobs that are made available at any given time).

Job Title: _____ **Name:** _____

Date: _____ **Claim#:** _____

Employer: **Your Company Name**
 Company Address
 Company Address
 Company Phone Number

MACHINERY, TOOLS, EQUIPMENT:

PHYSICAL DEMANDS

- Not applicable
- Frequent (30 - 70% of the time)
- Seldom (1 - 10% of the time)
- Occasional (10 - 30% of the time)
- Constant (over 70% of the time)

	Frequency	Comments	OK	Physician
Sitting				
Standing				
Walking				
Driving				
Lifting ___ lbs.				
Carrying ___ lbs				
Pushing/Pulling				
Climbing Stairs/Ladders				
Heights/Balancing				
Bending at Waist				
Twisting at Waist				
Kneeling/ Squatting				
Crawling				

Reaching Above Shoulder				
Repetitive Arm/Hand Movement				

Completed by: _____ Title: _____

FOR PHYSICIAN'S USE ONLY

_____ The injured worker can perform this job and can return to work on _____.

_____ The injured worker can perform this job on a part-time basis for _____ hours per day.

_____ The worker can be expected to return to regular duties by (date)_____

_____ The injured worker can perform the described job but only with modifications as noted in Comment section below.

_____ The injured worker cannot perform this job based on the following physical limitations:

Comments:

Physician's Signature: _____ Date: _____

****For an alternate fast way to put together a job description, go to:***

<http://www.lni.wa.gov/forms/pdf/252040af.pdf>

This is a one-page "Employer's Job Description" that you can fill in quickly, using pull-down menus for the frequency of the different categories of physical demands listed. However, YOU CANNOT SAVE THIS DOCUMENT. You must immediately print it because once you close it, your individualized information is gone forever.

(“DEAR DOCTOR” LETTER #1)

Your Company Letterhead

Date:

Doctor’s Name

Address

City, State, Zip Code

Re: *(Worker’s Name _____)*

Claim #:

Dear Dr. _____:

Your Company Name is committed to assisting our injured employees in returning to work as soon as possible. Attached is a job description for the position of _____. This position is for (*restricted/light duty, transitional work, job of injury job, modified version job of injury, new job, etc.*).

Please review and respond to the job description, outlining any needed modifications. If our employee is not able to work, please indicate what physical restrictions prevent return to work at this time. This position is currently available and we are waiting for your approval.

A self-addressed (stamped) envelope is enclosed for your convenience in returning the signed job description to me as soon as possible. If you have questions or comments, please call me at **Company Phone#**. Thank you for your assistance with our injured employee’s return to work.

Sincerely,

Company Claim Coordinator’s Name

Your Company Name

cc: ***L&I Claims Manager’s Name (if known)***
Department of Labor & Industries

Injured Employee’s Name

(“DEAR DOCTOR” LETTER #2)

(Date):

Re: (Employee’s Name)

Dear Dr. _____:

Perhaps you did not know this, but your patient suffers an immediate loss of 25% to 40% of their gross wages when you certify them as completely disabled. **(Company’s Name)** has developed a Return to Work program that allows us to modify job assignments or provide light duty positions for our employees who are unable to return to their normal duties while recovering from an industrial injury.

Attached is a job description for **(Employee’s Name)**. Please use this form to prescribe what limitations you wish to impose on our employee. **(Employee’s Name)** has agreed to return this job description signed by you, the attending physician, to me upon conclusion of **(his/her)** first treatment. We have an agreement with our employee to observe any medical restrictions until such time as you, the attending physician, deem it appropriate to life or modify these restrictions.

Should you wish to contact me now or at any time during our employee’s treatment to discuss problems or concerns, please don’t hesitate to call me at **(phone number)**.

Thank you for your time and attention to this matter.

Sincerely,

(Company Claims Coordinator’s Name)
(Company Name)

(JOB OFFER CONFIRMATION LETTER)

(Send this letter in **follow-up to verbal agreement** with employee to return to modified work)

Your Company Letterhead

Date:

Employee's Name

Address

City, State, Zip Code

Re: *Claim #* _____

Dear _____:

We look forward to having you back at work! Per our discussion on _____, your doctor has released you for modified duty work, which *he/she* feels you are able to do until you can return to your regular job. Therefore, we have offered you the temporary, modified duty job of _____. Attached is a copy of the job description approved by your attending doctor.

As we discussed, please report to your immediate supervisor for your modified duty job on (insert date) at (insert time AM/PM). Your pay will be \$ _____ *per* _____ (hour/month).

As you improve, the physical demands of the job may change, as approved by your doctor. Usually, a modified duty assignment lasts anywhere from a few days to several weeks, depending on your medical condition.

Your signature below confirms that you have reviewed and accepted this job offer. Please return this signed job offer agreement to me by (insert date).

Should you have any questions about this job offer, please contact me at Your Company Phone#. Again, we look forward to seeing you on (date back to work).

Sincerely,

Name

President

Your Company Name

Page 2
Job Offer Confirmation Letter
Employee's Name
Date of Letter

CHECK ONE:

I accept this job offer: _____

I do not accept this job offer: _____

Employee Signature

Date

Enclosures: Approved Job Description
 Extra Copy of this letter for employee's records

(FORMAL JOB OFFER LETTER)

(Send only if verbal communication is not possible)

Your Company Letterhead

Date:

Employee's Name

Address

City, State, Zip Code

Re: **Claim #** _____

Dear _____:

Your doctor has released you for modified duty work, which **he/she** feels you are able to do until you can return to your regular job. Therefore, we would like to offer you the temporary, modified duty job of _____. Attached is a copy of the job description approved by your attending doctor.

Please report to your immediate supervisor for your modified duty job on **(insert date)** at **(insert time AM/PM)**. Your pay will be \$_____ **per** _____ **(hour/month)**. Loss of Earning Power (LEP) benefits may apply if your restricted duty wage is less than your regular wage.

As you improve, the physical demands of the job may change, as approved by your doctor. Usually, a modified duty assignment lasts anywhere from a few days to several weeks, depending on your medical condition.

Your signature below indicates that you have reviewed this offer. Please return this signed job offer agreement to me by **(insert date—10 to 14 days from date of letter)**. A self-addressed, stamped envelope is enclosed for your convenience.

Should you have any questions about this job offer, please contact me at **Your Phone#**.

Sincerely,

Name

President

Your Company Name

Page 2
Job Offer Letter
Employee's Name
Date of Letter

CHECK ONE:

I accept this job offer: _____

I do not accept this job offer: _____

Employee Signature

Date

Enclosures: Approved Job Description
 Extra Copy of this letter for employee's records

JOB ASSIGNMENT AGREEMENT #2

“Return to Work Agreement”

Employee: _____ **Claim #:** _____

Start Date: _____ **End Date:** _____

*Per our modified return to work process, this agreement marks the beginning of (**Employee’s Name**) modified work assignment.*

*The job description approved by the doctor is attached. It is very important that only those approved tasks be performed. (**Employee’s Name**) is authorized only to do the tasks specifically identified as approved by the doctor.*

Welcome back to work. We are excited that we can provide this benefit to you and want to make your recovery as comfortable as possible. If you have any difficulties during this assignment period, please talk with your supervisor immediately.

*We will plan to meet on the (**end date**) to discuss treatment, progress and the next steps associated with your return to work.*

Company Claims Coordinator: _____ *Date:* _____

Supervisor: _____ *Date:* _____

Employee: _____ *Date:* _____

*Enclosures: Job description approved by doctor
Job offer letter*

*cc: Company claim file
Doctor’s Name
L&I Claims Manager
Employee’s Name
Supervisor’s Name*

JOB ASSIGNMENT AGREEMENT LETTER #3

“Restricted Job Assignment Agreement”

I understand that **Dr.** _____ has released me to return to work, provided that I do not exceed the physical restrictions outlined in the attached job description signed by my physician.

Employee: I agree to work within these restrictions. In the event that I am given an assignment which falls outside these restrictions or that is causing any difficulty in the performance of these duties or given a task beyond these restrictions, I will notify my supervisor immediately. I will not violate the restrictions as I understand them. I will work cooperatively with my supervisor to prevent re-injury or aggravation of my present physical condition. I further understand that these medical restrictions apply to my activities away from work.

Supervisor: I agree to assign only work within the medical restrictions outlined by the employee’s physician. If the employee is observed doing any task which falls outside these physical restrictions, I will immediately talk with the employee to resolve these problems. I will not violate the restrictions as I understand them. I will work cooperatively with the employee to prevent re-injury or aggravation of the employee’s present physical condition.

We agree to notify (**Company Name**)’s company claims coordinator if further assistance is needed.

Employee’s Name (Please Print)

Employee’s Signature

Supervisor’s Signature

Effective Date

Review Date

(LOSS OF EARNING POWER LETTER)- If applicable

Your Company Letterhead

Date: _____

Claim Manager's Name
Department of Labor & Industries
P.O. Box 44299
Olympia, WA 98504-4299

Re: **Employee Name**
Claim #_____

Dear **Claim Manager's Name**:

The above referenced claimant has been released for restricted duty by **his/her** attending physician. An approved job description signed by the doctor is enclosed, releasing **(employee's name)** for _____ **(hours/day)**, over an anticipated period of _____ days.

Since **(employee's name)** regular position pays \$_____ **per hour** and the restricted duty position pays \$_____, we are requesting LEP benefits in this case.

I will inform you immediately when **(employee's name)** has returned to regular duty at full pay.

Sincerely,

Company Claim Manager's Name
Your Company Name
Your Company Phone Number

****Note: The Department of Labor & Industries will respond to this request by mailing an LEP form. This must be completed by the employee, employer and attending physician and returned to the L&I Claims Manager at the end of each pay period. REMOVE THIS MESSAGE FROM THE LETTER IF SENT.**

(MEDICAL STATUS LETTER)

Your Company Letterhead

Date: _____

Doctor's Name

Address

City, State, Zip Code

Re: ***Employee's Name***

Claim # _____

Date of Birth: _____

Dear Dr. _____:

At your earliest convenience, please complete and return the enclosed progress report form so that we can accurately manage the return to work issues associated with the above referenced claim.

Please answer all questions and add any additional information that you think may assist us in our return to work efforts.

If you have any questions or need further information, please call me **Your Phone#**.

Thank you for your assistance in this matter. It is important for us to receive your immediate response. A self-addressed, stamped envelope is enclosed for your convenience. Thank you for your prompt assistance.

Sincerely,

Company Claim Coordinator's Name

Your Company Name

Enclosure

MEDICAL PROGRESS REPORT

Patient's Name: _____

Claim #: _____

Date of Injury: _____

PROGRESS REPORT QUESTIONS:		
1. Are there any changes in diagnosis, findings, complaints or treatment since last report? If yes, please explain:		
2. What is the date of last treatment? _____		
3. Will further treatment be necessary?		
4. Are there any conditions impeding recovery? If yes, what are they?		
5. Is patient able to return to regular work? If yes, date released: _____		
6. Can patient return to work with restrictions? If yes, what are patient's current physical restrictions?		
7. Is inability to work due <u>solely</u> to the industrial injury condition?		
8. Is there any permanent disability resulting from this injury? If yes, will you rate it? Yes___ No ___		
9. Do you recommend closure of this claim?		

Physician's Name (PLEASE PRINT)

Date

Physician's Signature

(CLAIM CLOSURE REQUEST LETTER)

Your Company Letterhead

Date: _____

Claim Manager's Name

Department of Labor & Industries

P.O. Box 44299

Olympia, WA 98504-4299

Re: ***Employee's Name***

Claim #: _____

Dear Claim Manager's Name:

Attached is a statement by ***(employee's name)*** attending physician stating that this claimant's medical condition is fixed and stable and that further treatment is not indicated.

We are requesting at this time that you proceed with claim closure. Attached is the supporting documentation for this request.

Thank you.

Sincerely,

Company Claim Coordinator's Name

Your Company Name

Your Phone#