

GENERAL RETURN TO WORK (RTW) GUIDELINES

Note: These guidelines are general in nature and intended to provide a basic framework to help you through the RTW process.

- Specific legal obligations are set out by the employment, human rights, health and safety, and workers' compensation legislation that apply to your organization: provincial, territorial, or federal, as the case may be. It is important that the employer understand and adhere to the correct legislative requirements.
- The sample forms provided here are the basics. External bodies involved with an employee's injury/illness, for example, disability insurance companies and workers' compensation boards, will have their own specific forms that must be completed.
- Please refer to your health and safety policies / legislation regarding additional specific obligations in the case of work-related injuries/illness.
- Each RTW situation is unique and needs to be assessed on the specific circumstances.
- If in doubt at any time, you are strongly encouraged to speak with an HR professional and/or employment lawyer.

An ounce of prevention is worth a pound of cure. Benjamin Franklin

OVERVIEW

One of the more challenging HR situations is dealing with an employee who is off work due to injury/illness, work-related or otherwise. In either case, the employer has legal obligations (Human Rights, Health and Safety, Workers' Compensation as appropriate), including return to work (RTW) and accommodation. The worst thing to do is to be an ostrich: burying your head in the sand and hoping that the issue resolves itself on its own (it rarely does). Every situation has to be assessed and managed on its own merits so thoughtful planning and diligent execution are key.

A timely return to work is beneficial for both the organization and the employee. Research shows that the longer an employee is away from work, the more difficult it is to return. This is where regular communications, including encouragement and workplace updates, become important in the RTW process so that the employee does not feel isolated and uncomfortable returning to a possibly changed environment. Developing a RTW policy and communicating it with all employees is a sound first step so employees know what to expect in the event they cannot work due to extended illness/injury.

Key to a successful RTW process:

1. Have a RTW policy/procedure in place.
2. If not the immediate supervisor, appoint somebody within the organization dedicated to vigilantly and diligently manage the entire process from “day one”. Do not wait until the employee contacts you when they are ready to return to work.
3. Collaborate from the start with the workers' compensation board or disability insurance company, as the case may be. These external parties deal with injuries, illness and RTW processes every day and are great partners in successfully managing RTW situations – if you engage with them in a sincere manner. If your organization does not have disability insurance, or the illness/injury is not a workers' compensation matter, you still have RTW and accommodation obligations.
4. Stay in touch with the employee – respectfully, without being a nuisance. Let them know that you sincerely wish to help them return to work in a timely and safe manner, explain the process and their role.
5. Keep detailed documentation at every step of the RTW process.
6. Ensure that you have the information that you need to make sound decisions.
7. Respect privacy and confidentiality. Medical information should only be shared on a “need to know” basis and must be kept confidential.
8. Own the process until the very end.

A successful RTW is a “win-win” for everybody.

SAMPLE RETURN TO WORK POLICY

EMPLOYER NAME is committed to a safe and healthy work environment and a Return to Work (RTW) program is a best practice that combines a responsible approach towards returning ill/injured employees to work while maintaining our commitment of protecting the health and welfare of all employees. Our RTW program strives to assist injured/ill employees to make an early/timely and safe return to their regular duties. The RTW process commences immediately after an injury or illness occurs.

In the event an employee suffers an injury or illness, **EMPLOYER NAME** commits to taking all reasonable steps to strive to provide for the safe and timely return to work (RTW) of the employee including providing transitional, alternative, or modified work, as reasonable and as medically supported. Where possible, it is anticipated that the employee will increase the proportion of the pre-injury/illness duties during the program for a progressive return to the pre-injury/illness job.

Modified work is a means of accommodating an employee's medical restrictions and represents work that may be performed safely by an employee experiencing diminished capabilities resulting from illness or injury. Individuals who are provided with modified duties tend to return to their pre-injury positions in a shorter period of time and with fewer continuing problems. A broad approach to accommodation will be adopted that recognizes the unique circumstances in each case. This may include modifications of the pre-injury job, temporary assignment to a different job, or modifying work hours. Modified duties / accommodations will be determined on a case by case basis and must be meaningful, productive and valuable to the organization. The **EMPLOYER NAME** will attempt to place all employees based on their physician's recommendations, however, it may not always be possible to arrange modified work and /or provide accommodations.

Our RTW can only be successful with the full participation of all parties. As such, this policy applies to all employees in the organization. **EMPLOYER NAME** will work in collaboration with employees who are unable to perform their regular work due to injury/illness to try and identify suitable work and develop individualized RTW work plans based upon functional abilities information provided by the healthcare providers. Injured/ill employees must cooperate with the RTW process. Co-workers are expected to provide support and encouragement to employees participating in the RTW program.

SAMPLE RETURN TO WORK PROCEDURES

(This sample assumes that the immediate supervisor will manage the entire process. Substitute RTW coordinator / HR / another title where this is not the case)

Communicate

1. If an injury/illness results in time off work, the employee will contact the immediate supervisor to advise them of the length of expected absence, begin to discuss return to work and any anticipated accommodation that may be necessary upon return.
2. The supervisor will maintain contact with the employee on a weekly basis and/or at suitable intervals. The employee is responsible for keeping the supervisor advised of any changes in his or her physical condition.
3. Both the employee and the supervisor are responsible for maintaining contact with any external bodies that may also be involved, such as a disability insurance provider or workers' compensation board, as necessary, and for providing necessary documentation.

Gather information

4. The supervisor must create a case file that will include detailed notes from all conversations, meetings, requests, research, decisions, regarding the case along with all correspondence with employees, health specialists, and other stakeholders.
5. The employee's job description must be reviewed to ensure it is current, or created if non-existent, and contain sufficient detail to assist a healthcare professional's evaluation regarding an employee's return to work, with or without modified duties or accommodations.
6. The supervisor must ensure the employee is provided a Return to Work Letter letter and consent form, a Functional Abilities Form (FAF) and their job description to take to their doctor for the purpose of requesting information about their ability to return to work, either to the pre-injury job or to modified duties, if available.
 - Written medical clearance from the employee's doctor is required **before** the individual returns to work, either to their original job or to modified duties. This is required to ensure the safety of the injured/ill employee as well as the safety of the other employees.

Assess the situation and options

7. Upon receipt of a completed Functional Abilities Form, the supervisor will compare the FAF with the requirements of pre-illness/injury job.
 - If the employee is deemed fit to return to work without any restriction by the physician, he/she must be returned to the pre- injury/illness job.
 - If the employee's doctor has noted any specific restriction(s) concerning the employee's ability to work, the supervisor will explore available accommodation options consistent with the medical information provided and that also make sense for the organization. Accommodations are not about catering to an employee's likes or dislikes. Employers have an obligation to accommodate to the point of undue hardship which can be a challenging threshold. Discuss any refusal to accommodate with an advisor/legal counsel first.

Develop a Return to Work Plan

8. When the employee is fit to return to work with modifications / accommodations, as confirmed by the treating physician, the supervisor and employee should discuss the modifications / accommodations and, where possible, develop a return to work plan together.
9. The supervisor will make a written offer of modified work and a RTW plan for the employee to review and sign, noting that the necessary restrictions are being observed and specifying the number of weeks, hours of work, any accommodations, review dates, and any other pertinent details.
10. The employee has an obligation to actively participate in the RTW process.

Implement the Return to Work Plan

11. The supervisor will meet with the employee on the first day back at work to welcome them back, review the RTW plan again, and address any questions that the employee may have.
12. The supervisor will monitor the effectiveness of the RTW plan by regularly checking in with the employee at least once a week to review their progress against the RTW plan and make any reasonable modifications as needed and, if appropriate, supported by the employee's doctor.
13. The Return to Work plan duration will depend on the circumstances. Extensions can be provided when medical opinion warrants.

GENERAL RESPONSIBILITIES OF EMPLOYERS AND EMPLOYEES

(This is an abbreviated and non-exhaustive list)

Employee Responsibilities

- ⇒ Report as promptly as possible any injury/illness to immediate supervisor.
- ⇒ Fully cooperate and participate in the Return to Work (RTW) process.
- ⇒ Obtain and complete any necessary paperwork.
- ⇒ Maintain regular contact with immediate supervisor, from the start of the illness/injury and throughout the entire recovery period. At a minimum, barring extenuating circumstances, the employee must call in weekly to advise of their progress and of any changes.
- ⇒ Advise the treating physician of the RTW program and the possibility of modified duties / accommodations.
- ⇒ Provide the treating physician with the Functional Abilities Form (FAF), job description and their consent to release the completed FAF to their employer so that the physician may clarify health restrictions and describe the type of modifications / accommodation that would be most effective to facilitate the employee's return to work.
- ⇒ Return the FAF completed by the treating physician as soon as possible to the immediate supervisor.
- ⇒ Allow a reasonable amount of time for the employer to review the FAF and/or to reply to requests for accommodation.
- ⇒ Participate in discussions regarding possible modifications / accommodation solutions, consider any reasonable options that the employer proposes, and, where possible, participate in the development of a specific Return to Work plan.
- ⇒ Strive to meet the expectations set out in RTW once modifications / accommodation(s) are provided.
- ⇒ Communicate with the immediate supervisor on an ongoing basis during the RTW process, including any difficulties or concerns regarding the duties / accommodations provided, and advise as their condition improves/changes.

Employer Responsibilities

- ⇒ Respond promptly to the employee's notice of illness/injury.
- ⇒ Maintain regular contact with the employee during their absence from work.
- ⇒ Ensure the employee is aware of the Return to Work (RTW) policy / process.
- ⇒ Take notes and keep records of all discussions and matters related to the injury/illness and RTW and ensure timely completion and submission of necessary documents.
- ⇒ Provide the employee with a Return to Work Letter letter and consent form, a Functional Abilities Form (FAF) and their job description to take to their doctor.
- ⇒ Maintain any medical information received in a confidential manner.
- ⇒ Liaise with external bodies that may also be involved, such as a disability insurance provider or workers' compensation board, as relevant.
- ⇒ Review medical information and functional abilities information to assess and explore options for modified work / accommodations, if possible and if needed.
- ⇒ If necessary, request additional time to assess accommodation requests when provided with short notice and/or additional information if the requests raise concerns.
- ⇒ Work with the employee to discuss and design the RTW plan, where possible.
- ⇒ Formalise the RTW plan in writing with the employee.
- ⇒ Meet regularly with the employee during the work plan to monitor progress and any concerns the employee may have, and make modifications, as appropriate and with medical confirmation if necessary.
- ⇒ Seek advice at any step along the way, if needed.

SAMPLE EMPLOYEE RETURN TO WORK LETTER

DATE

NAME
ADDRESS
CITY, PROVINCE, POSTAL CODE
PHONE NUMBER

Dear **EMPLOYEE NAME**:

We are sorry to hear of your **illness / injury** and wish you a speedy recovery. We look forward to your return to active employment and are committed to trying to provide transitional work and/or modified work to accommodate your **illness/injury**. We appreciate our obligations and believe that providing appropriate work to meet your capabilities during the healing process of your **injury/illness** is the most positive approach to successful rehabilitation and a safe return to work.

In order to accommodate any restrictions that you may have, we require your treating healthcare professional to complete a Functional Abilities Form (FAF). To that end, we have attached to this letter a Functional Abilities Form and a job description for you to take to your doctor for completion. We have also attached a letter of explanation for the doctor where you are also requested to sign your consent for the doctor to release the completed FAF to us. The FAF will help us to assess your capabilities to return to work and to evaluate if we have any suitable work available. If applicable, a Return to Work plan will then be developed and provided to you.

Please return the completed Functional Abilities Form to us immediately after visiting your doctor. We would appreciate this form returned to us no later than **DATE**. If your doctor charges a fee for the completion of the FAF, please submit this invoice to **EMPLOYER NAME** for reimbursement.

We would like to kindly remind you that, during this process, you have an obligation to keep in contact with us on a regular basis and to cooperate with our return to work program.

Please call me if you have any questions at **PHONE NUMBER**.

Yours truly,

NAME
Title

SAMPLE HEALTH CARE PROFESSIONAL LETTER

DATE

<DR's NAME>
<DR.'s ADDRESS>

Re: **EMPLOYEE NAME**

Dear Doctor:

EMPLOYER NAME is committed to returning injured or ill employees to work, either to their pre-injury job or to transitional modified work following an injury or illness. To ensure that the employee is able to return to work safely, and in a timely manner, we request that the following Functional Abilities Form be completed to provide us with information on the employee's current abilities. We have also included the employee's job description for your reference.

As appropriate, we will attempt to accommodate **EMPLOYEE NAME'S** medical restrictions including possible (temporary) modifications to his/her regular job tasks and/or hours of work if required.

If you require any further information/clarification, please do not hesitate to contact me at **PHONE NUMBER.**

The employee's signature below confirms consent to the release of this information by you to us.

Yours truly,

Name
Title

Att. Functional Abilities Form and Job Description

Employee/Patient Consent to the release of Functional Abilities Information

I _____ (Print Employee Name) authorize any health care professional who treats me, to provide my employer (**EMPLOYER NAME**), and, as relevant, the insurance provider and/or the worker's compensation board, with information about my functional abilities and any limitations/restrictions affecting my ability to return to work as set out on the attached Functional Abilities Form.

Employee / Patient Signature

Date

SAMPLE FUNCTIONAL ABILITIES FORM - RETURN TO WORK INFORMATION

EMPOYEE NAME: _____

PHYSICIAN NAME: _____

	No Restrictions	Restrictions Required	Specific Guidelines
1. MOVEMENT			
a) Walking			
b) Standing			
c) Sitting			
d) Climbing			
e) Kneeling			
f) Bending			
g) Pushing / Pulling			
h) Twisting			
j) Other			
2. LIFTING			
a) Above chest level			
b) Below knees			
c) Weight limitations			Can lift up to _____ kg/lbs.
d) Carrying			
e) Other			
3. UPPER LIMB USE			
Problem side: R L			
a) Movement above shoulder			
b) Grasping / Hand function			
c) Repetitive use of _____			
4. OTHER			
a) Attention/Concentration			
b) Ability to multi-task			
c) Communication			
d) Organization/Planning			
e) Ability to safely drive / operate potentially dangerous equipment.			
f) Additional factors/issues that will affect his/her work? <i>Please describe</i>			

5. Patient's ability to return to work (CHECK ONLY ONE):

- Able to return to work immediately without restrictions.
- Unable to participate in any work, including modified duties for: _____ days or _____ weeks.
- Able to return to modified duties:
 - i. Duration of restrictions: _____ days _____ weeks
 - ii. Recommended Work Hours: _____ Full-time _____ Modified _____ Graduated
 - iii. Additional comments regarding: recommendations, restrictions, accommodations, effects of medication, timelines for increasing duties to the employee's return to their full pre-injury position, other:

6. Is complete recovery expected? _____ Yes _____ No _____ Uncertain

- i. If "Yes", when do you anticipate a full return to the employee's pre-injury job?**

7. Next Appointment: _____

Name of Physician (Please Print)

Date

Signature of Physician

Telephone #

Address: _____

SAMPLE OFFER OF MODIFIED WORK LETTER AND RETURN TO WORK PLAN

EMPLOYEE NAME

Dear **Employee**:

We look forward to your return to active employment. In this document, we are providing you with a return to work plan that accommodates your **illness/injury** to facilitate your safe return. It is expected that both parties will co-operate in the implementation of this plan and will communicate with each other in an effort to achieve a successful outcome.

As discussed in our meeting on _____, we recognize your present medical restrictions:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

and agree to provide the following temporary accommodations based on these restrictions:

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Start Date: _____ Hours of work: _____

Review Date: _____ Other: _____

Every effort must be made by you to attend work. If you are unable to do so, you must notify your supervisor immediately.

We recognize that a return to work plan may involve an ongoing process of trial and evaluation and that amendments to the plan may become necessary. If you have any concerns at any time, you must raise these immediately so that we can work towards their resolution. Working together will ensure that your return to work is safe, timely and supports your full recovery.

Thank you for your co-operation.

Name

Title

I _____ (Print Employee Name),

accept the modified duties that my employer is offering to me.

reject the modified duties that my employer is offering to me.

(please check
only one box)

Employee Signature

Date