

Dear Insured:

West Bend is pleased to provide you with ...

1. Workers' Compensation reporting tips that are helpful when you must report a work-related injury.
2. Employer's First Report of Injury or Disease form.
3. Supervisor's Incident Report.
4. A description of our cost containment initiatives.

The following forms are also available and are helpful in returning your employee to work ...

1. **Job Analysis.** (WB 501) Use this form when working with the treating physician.
2. **Attending Physicians Return to Work Recommendations Record.** (WB 531) Send this with the injured employee to the initial treating doctor's appointment. You may ask the employee to return the form directly to you after initial medical treatment, or ask the doctor to fax it back to you.
3. **Return to Work Log.** (WB 603) Use this log as an efficient method to monitor and document the specific tasks your employees are performing while on light or modified duty.

We hope you find this information useful.

Sincerely,

Workers' Compensation Claim Department

WORKERS' COMPENSATION REPORTING TIPS

– ATTENTION– YOU MAY BE FINED IF YOU DO NOT REPORT ON THE JOB INJURIES PROMPTLY

If an accident occurs at your workplace, you must complete an Employers First Report of Injury form IMMEDIATELY and forward the form to us even if you don't have all the information about the injury. If the form isn't submitted to us soon after the injury occurs, you may be fined by the State.

When reporting an injury:

- Do not wait for medical bills.
- Do not withhold or delay reporting the loss because you believe the claim is questionable. Reporting a loss is not an admission of liability.
- Be sure to include your policy number on all correspondence you send to us.

You can report an injury by mail, phone, fax, or email.

Workers' Compensation Claims Department
West Bend Mutual Insurance Company
1900 S. 18th Avenue
West Bend, WI 53095
Phone: 800-236-5010, extension 5247
FAX: 262-334-6378
e-mail: directconnect@wbmi.com

General Questions:

Phone: 800-236-5004 or 334-6430
e-mail: wccentral@wbmi.com

Do not withhold the loss report for any reason. Send, fax, call, or e-mail it **IMMEDIATELY** after the injury occurs. **You may be fined** if the claims administrator cannot make the initial lost time payment because you failed to send the Employer's First Report of Injury on time.

If you fax or e-mail the report, please do not send it. If you need to notify your agent, please send your agent a photocopy of the report. Direct reporting saves time.

If you have any questions, please call your claims administrator.

HOW TO WRITE INJURY DESCRIPTIONS

The following instructions will help you avoid some common errors and save time when describing an injury on the First Report of Injury form.

For most accidents, you can describe what happened in one or two sentences. "He strained his lower back lifting a box." "She bruised her left knee when she fell on a wet floor." However, your descriptions must be specific. "Hurt back working" does not provide enough information.

Answer the following questions when describing an injury:

1. What part of the body was injured?

- Lower back
- Right forearm
- Upper right leg
- Third toe on left foot

2. How did the accident happen?

- Did the person fall?
- Did they twist their body as they got out of a chair?
- Were they moving or stationary when the accident happened?

3. Was the injured person carrying anything?

Even if it probably didn't cause the injury, we need to know if the person was carrying anything. For example, "Carrying broom, stepped wrong and twisted left ankle."

4. What specifically appears to have caused the accident?

If someone hurt their back lifting a box, say that. Don't say:

- Lifting a unit of material
- They hurt their back lifting product
- Lifting equipment

Avoid jargon or trade names for equipment. Explain precisely what they were doing.

- Lifting an air conditioner
- Pushing a cart
- Carrying magazines
- Bending over to pick up a wrench

If a machine caused the injury, tell us what kind.

- A grinder
- A shear
- A hoist

Again, avoid jargon or trade names.

5. What injury appears to have resulted?

- Strain
- Fracture
- Bruise
- Cut

Please be sure to include the injured person's birthdate and Social Security number. Also, indicate the geographical location of the accident (city, county and state).



WORKERS' COMPENSATION

is a system of benefits provided by law to most workers who have job-related injuries or illnesses. Benefits are paid for injuries that are caused, in whole or in part, by an employee's work. This may include the aggravation of a pre-existing condition, injuries brought on by the repetitive use of a part of the body, heart attacks, or any other physical problem caused by work. Benefits are paid regardless of fault.

IF YOU HAVE A WORK-RELATED INJURY OR ILLNESS, TAKE THE FOLLOWING STEPS:

- 1. GET MEDICAL ASSISTANCE.** By law, your employer must pay for all necessary medical services required to cure or relieve the effects of the injury or illness. Where necessary, the employer must also pay for physical, mental, or vocational rehabilitation, within prescribed limits. The employee may choose two physicians, surgeons, or hospitals. If the employer notifies you that it has an approved Preferred Provider Program for workers' compensation, the PPP counts as one of your two choices of providers.
- 2. NOTIFY YOUR EMPLOYER.** You must notify your employer of the accidental injury or illness within 45 days, either orally or in writing. To avoid possible delays, it is recommended the notice also include your name, address, telephone number, Social Security number, and a brief description of the injury or illness.
- 3. LEARN YOUR RIGHTS.** Your employer is required by law to report accidents that result in more than three lost work days to the Workers' Compensation Commission. Once the accident is reported, you should receive a handbook that explains the law, benefits, and procedures. If you need a handbook, please call the Commission or go to the Web site.

If you must lose time from work to recover from the injury or illness, you may be entitled to receive weekly payments and necessary medical care until you are able to return to work that is reasonably available to you.

It is against the law for an employer to harass, discharge, refuse to rehire or in any way discriminate against an employee for exercising his or her rights under the Workers' Compensation or Occupational Diseases Acts. If you file a fraudulent claim, you may be penalized under the law.

- 4. KEEP WITHIN THE TIME LIMITS.** Generally, claims must be filed within three years of the injury or disablement from an occupational disease, or within two years of the last workers' compensation payment, whichever is later. Claims for pneumoconiosis, radiological exposure, asbestosis, or similar diseases have special requirements.

Injured workers have the right to reopen their case within 30 months after an award is made if the disability increases, but cases that are resolved by a lump-sum settlement contract approved by the Commission cannot be reopened. Only settlements approved by the Commission are binding.

For more information, go to the Illinois Workers' Compensation Commission's Web site or call any office:

Toll-free: 866/352-3033 Chicago: 312/814-6611 Peoria: 309/671-3019 Springfield: 217/785-7087

Web site: www.iwcc.il.gov Collinsville: 618/346-3450 Rockford: 815/987-7292 TDD (Deaf): 312/814-2959

BY LAW, EMPLOYERS MUST DISPLAY THIS NOTICE IN A PROMINENT PLACE IN EACH WORKPLACE AND COMPLETE THE INFORMATION BELOW.

Party handling workers' compensation claims	WEST BEND MUTUAL INSURANCE COMPANY		
Business Address	1900 SOUTH 18TH AVENUE, WEST BEND, WI 53095		
Business Phone	1-800-236-5004		
Effective Date		Termination Date	
Policy Number		Employer's FEIN	

INDEMNIZACIÓN DEL TRABAJADOR

Es un sistema de beneficios que provee la ley a la mayor parte de trabajadores que se han lastimado o han contraído una enfermedad relacionada con su trabajo. Los beneficios se pagan en casos donde las lesiones han ocurrido parcial o totalmente por el trabajo del empleado. Estas lesiones pueden ser el empeoramiento de una condición que previamente existía, lesiones ocasionadas por el uso repetitivo de una parte del cuerpo determinada, ataques al corazón o cualquier otro problema causado por las condiciones de trabajo. Dichos beneficios se le pagan al empleado sin importar de quien haya sido la culpa.

SI USTED SUFRE DE UNA ENFERMEDAD O LESIÓN RELACIONADA CON SU TRABAJO, USTED DEBE DE HACER LO SIGUIENTE:

- BUSQUE ASISTENCIA MEDICA.** Por ley, su patrón esta obligado a pagar por todos los servicios médicos que se requieran para curar o aliviar los efectos de su enfermedad o lesión. El empleado puede escoger a dos médicos, cirujanos u hospitales. En casos necesarios, el empleador también tendrá que pagar por rehabilitación física, mental o vocacional dentro de los términos que antes se hayan establecido.
- NOTIFIQUE A SU PATRON.** Usted cuenta con 45 días para informarle, oralmente o por escrito, a su patrón acerca de su accidente o enfermedad. Para evitar posibles retrasos, se recomienda que usted incluya en este reporte, su nombre, dirección, número de teléfono, número de seguro social y una breve descripción de su lesión o enfermedad.
- SEPA CUALES SON SUS DERECHOS.** Por ley, su patrón esta obligado a reportar cualquier accidente que resulte en la pérdida de tres o mas días de trabajo a la Comisión de Indemnización del Trabajador. Una vez que se haya hecho el reporte, usted recibirá un manual en el cual se explica la ley, los beneficios y el tramite en general. Si usted necesita un manual, por favor llame a Comisión o visite su sitio Web.

Si usted tiene que perder días de trabajo para recuperarse de su lesión o enfermedad, usted puede tener el derecho de recibir pagos semanales y el cuidado médico necesario hasta que usted esté capacitado para regresar. Su posición deberá estar razonablemente disponible para usted.

Es en contra de la ley que su patrón lo acose, lo despida, le niegue contratarlo nuevamente o lo discrimine por darle seguimiento a los derechos con que usted cuenta bajo la Indemnización del Trabajador o los Decretos de Enfermedades Ocupacionales (Occupational Diseases Acts). Si usted presenta una demanda fraudulenta, usted puede ser penado por la ley.

- MANTENGASE DENTRO DE LOS LIMITES.** Generalmente las demandas deben presentarse en el transcurso de tres años después de que haya sucedido el incidente relacionado con su trabajo o dos años después de haber recibido su último pago de indemnización del trabajador. Presente la demanda de acuerdo lo que haya sucedido mas recientemente. Demandas que tengan que ver con neumoconiosis, exposición radiológica, asbestosis o enfermedades similares, tienen requisitos especiales.

Los trabajadores cuya incapacidad ha empeorado, tienen derecho de abrir su caso nuevamente en el transcurso de 30 meses después de haber recibido su indemnización. Los empleados que acordaron recibir una cantidad fija en su contrato con la Comisión, no podrán abrir su caso nuevamente. Solamente aquellos casos aprobados por la Comisión, podrán abrirse nuevamente.

Para obtener mas información visite el sitio Web de Illinois Workers' Compensation o llame a cualquiera de estas oficinas:

Gratis: 866-352-3033 Chicago: 312-814-6611 Peoria: 309-671-3019 Springfield: 217-785-7087
 Sitio Web: www.iwcc.il.gov Collinsville: 618-346-3450 Rockford: 815-987-7292 TDD (para sordos): 312-814-2959

POR LEY, TODO EMPLEADOR DEBERA COMPLETAR LA INFORMACION A CONTINUACION Y TENER ESTE AVISO EN UN LUGAR VISIBLE EN EL LUGAR DE TRABAJO			
Encargado del manejo de las demandas de la indemnización del trabajador	WEST BEND MUTUAL INSURANCE COMPANY		
Dirección del negocio	1900 SOUTH 18TH AVENUE, WEST BEND, WI 53095		
Teléfono del negocio	1-800-236-5004		
Fecha de vigencia		Fecha de finalización	
Número de la póliza		FEIN del empleado	

ILLINOIS FORM 45: EMPLOYER'S FIRST REPORT OF INJURY

Please type or print.

Employer's FEIN	Date of report	Case or File #	Is this a lost workday case? Yes No
Employer's name		Doing business as	
Employer's mailing address			Employer's email address
Nature of business or service			SIC code
Name of workers' compensation carrier/admin.		Policy/Contract #	Self-insured? Yes No
Employee's full name			Birthdate
Employee's mailing address			Employee's e-mail address
Gender Male Female	Marital status Married Single	# Dependents	Employee's average weekly wage
Job title or occupation			Date hired
Time employee began work	Date and time of accident		Last day employee worked
If the employee died as a result of the accident, give the date of death.		Did the accident occur on the employer's premises? Yes No	
Address of accident			
What was the employee doing when the accident occurred?			
How did the accident occur?			
What was the injury or illness? List the part of body affected and explain how it was affected.			
What object or substance, if any, directly harmed the employee?			
Name and address of physician/health care professional			
If treatment was given away from the worksite, list the name and address of the place it was given.			
Was the employee treated in an emergency room? Yes No		Was the employee hospitalized overnight as an inpatient? Yes No	
Report prepared by	Signature	Title and telephone #	Email address

Please send this form to: **ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE RD SPRINGFIELD, IL 62703**
 By law, employers must keep accurate records of all work-related injuries and illness (except for certain minor injuries). Employers shall report to the Commission all injuries resulting in the loss of more than three scheduled workdays. Filing this form does not affect liability under the Workers' Compensation Act and is not incriminatory in any way. This information is confidential. IC45 8/12

FORMULARIO 45 – ILLINOIS: PRIMER INFORME DE LESIÓN DEL EMPLEADOR

Escriba a máquina o en letra de imprenta

FEIN del empleador		Fecha del informe		N.º de caso o archivo		¿Es este un caso con días de trabajo perdidos?	
Nombre del empleador				Nombre comercial			
Dirección postal del empleador							
Naturaleza del negocio o servicio					Código SIC		
Nombre de la aseguradora o el administrador de la compensación laboral West Bend Mutual Insurance Co. / Fax: 262-334-6378			Póliza/N.º de contrato			¿Autoasegurado?	
Nombre completo del empleado				Número de seguro social		Fecha de nacimiento	
Dirección postal del empleado						Dirección de correo electrónico del empleado	
¿Hombre/Mujer?		¿Soltero/Casado?		Número de dependientes		Salario semanal promedio del empleado	
Nombre del cargo u ocupación					Fecha de alta		
Hora a la que el empleado comenzó a trabajar			Fecha y hora del accidente		Último día que trabajó el empleado		
Si el empleado murió como consecuencia del accidente, dé la fecha de la muerte				¿Ocurrió el accidente en el local del empleador?			
Dirección donde ocurrió el accidente							
¿Qué estaba haciendo el empleado cuando ocurrió el accidente?							
¿Cómo ocurrió el accidente?							
¿Cuál fue la lesión o enfermedad? Escriba la parte del cuerpo afectada y explique cómo fue afectada							
¿Qué objeto o sustancia, si lo hubo, le hizo daño directamente al empleado?							
Nombre y dirección del médico o profesional de atención sanitaria							
Si se proveyó tratamiento fuera del lugar de trabajo, escriba el nombre y la dirección del lugar donde fue provisto.							
¿Fue tratado el paciente en una sala de urgencias?				¿Estuvo el empleado hospitalizado de un día para otro?			
Informe preparado por			Firma			Cargo y número de teléfono	

Por favor, envíe este formulario a:

ILLINOIS WORKERS' COMPENSATION COMMISSION 4500 S. SIXTH ST. FRONTAGE ROAD SPRINGFIELD, IL 62703-5118

Por ley, los empleadores deben mantener registros exactos de todas las lesiones y enfermedades relacionadas con el trabajo (excepto ciertas lesiones)

**WB 110 (05-11) West Bend Mutual Insurance Company
WC 8188t (06-09) UNIFORM**

menores).

Los empleadores deben informar a la Comisión de todas las lesiones que den lugar a la pérdida de más de tres días programados de trabajo. El presentar este formulario no afecta la responsabilidad bajo la Ley de Compensación por Accidentes de Trabajo y no es en ninguna forma incriminatorio. Esta información es confidencial. IC45 6/09

SUPERVISOR'S INCIDENT REPORT

Injury (work related)
 Illness (work related)
 Property Damage
 Incident

Employee Name (First, Middle, Last)			Social Security Number			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Employee Home Telephone Number		
Employee's Street Address						City		State		Zip
Age	Birthdate Mo. Day Yr.		Job Title			Department				
Employee's Scheduled Work Week When Injured		Start Time AM PM	End Time AM PM	Hrs. Per Day	Hrs. Per Wk.	Days Per Wk.	Normal Full-Time Schedule for Injured's Work	Start Time AM PM		End Time AM PM
Injury Date Mo. Day Yr.		Hour of Day AM PM		Last Day Worked Mo. Day Yr.		Start Date Mo. Day Yr.		<input type="checkbox"/> No Lost Time <input type="checkbox"/> Date Returned to Work Mo. Day Yr. <input type="checkbox"/> Estimated Date of Return		

Did employee seek medical attention? Yes No If yes, name of treating physician: _____

Name of clinic or hospital: _____

Will the employee complete a drug screening? Yes No

Names of Witnesses (Attach witness statements.)

1. _____ 2. _____

Injured Employee's statement of what happened. (Identify circumstances and equipment involved.)

How could this incident have been prevented?

What corrective action has been taken?

What is the injury/illness? (Be specific.)

Part of Body Affected

- Eye
- Head
- Neck
- Back
- Arm
- Shoulder
- Fingers
- Leg
- Knee
- Hip
- Foot
- Wrist
- Hand
- Toes
- Ankle
- Elbow
- Trunk (Other than back)
- Other

Type of Injury

- Cut/Abrasion
- Bruise/Contusion
- Foreign Object
- Burn
- Break
- Sprain/Strain
- Exposure
- Repetitive Motion
- Other

I believe that the answers to the above questions are true to the best of my knowledge.

Employee's Signature _____ Date _____

Supervisor's Signature _____ Date _____

Notified

WORKERS COMPENSATION COST CONTAINMENT INITIATIVES

West Bend Mutual Insurance Company participates in several medical cost containment initiative programs. The use of these programs helps reduce your workers' compensation expenses. A brief summary of each program is outlined below.

If you have any questions about any of the programs we offer, please call our Workers' Compensation Claim Department at 1-800-236-5004.

PHARMACY PROGRAM

This program is designed to provide discounts on workers' compensation prescriptions submitted by your injured employees. This service is provided by a national pharmaceutical management company using a network of retail pharmacies.

How the program works:

1. The injured employee files a workers' compensation claim with employer, seeks medical treatment, and receives a prescription from a physician.
2. The injured employee presents the prescription along with the temporary ID form to a participating pharmacy where the claim is electronically submitted by the pharmacy to our vendor.
3. Once West Bend receives notification of the claim from the employer, an employee-specific ID drug card is issued, along with a list of participating pharmacies and instructions on the use of the program.
4. The injured employee presents the ID drug card to a participating pharmacy for any future workers' compensation prescriptions.
5. High-cost/long-term-use medications are conveniently supplied through our vendor's mail service pharmacy.

DIAGNOSTIC TESTING PROGRAM

Using the services of a diagnostic management vendor, we can save money on any diagnostic test (i.e., CT scans, MRIs, EMGs, etc...) the treating doctor orders for injuries an employee sustains in a work-related injury. Our vendor will schedule the test, then notify the injured employee of the date and time. Once the test is performed, the films/x-rays will be forwarded to the referring physician.

To make this program successful, we ask that you encourage your employees to contact their West Bend claim representative as soon as they know a test will be ordered. We will handle it from there.

MEDICAL COST CONTAINMENT

Strong medical management brings about the early and safe return to work of your employees and reduces claim costs. To accomplish this, we contract with a medical bill review service. All of our medical provider charges (hospital, physician, physical therapist, chiropractor, and pharmaceutical) are verified for the appropriateness of the charge, and to determine if they adhere to state mandated fee schedules or local usual and customary (U&C) reimbursement levels.

Another way we are containing costs is through the use of a PPO Network. The Preferred Providers have agreed to discount their billings for the treatment of your industrially injured employees. This in turn keeps your premium costs down.

Your support in encouraging your injured workers to use a PPO provider is important. It sends an important message to the medical care providers that we support them in their effort to offer quality, cost effective care to patients.

For a list of PPO's in your area, please visit our website, www.thesilverlining.com for a link to the PPO list. Click on the "Claims" tab and then click on "How to Report a Claim" for the link "PPO Directory." The link is found toward the bottom of the webpage.



**WEST BEND MUTUAL INSURANCE COMPANY
WORKERS' COMPENSATION PRESCRIPTION INFORMATION**

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

Employee Name:	
Group #:	10602270
Member ID (SSN):	
Date of Injury:	
Claim Number:	
Processor:	myMatrixx
Bin #:	014211
Day supply is limited to 30 days for a new injury	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:
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Injured Worker:

West Bend has partnered with **myMatrixx** to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. **myMatrixx** has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call **myMatrixx** toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist: Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling **myMatrixx** for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All other will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900



AUTHORIZATION TO DISCLOSE NON-PUBLIC PERSONAL HEALTH INFORMATION AND WAIVER OF PRIVILEGE

TO: Patient Name:
Claim Number:

- 1. I, _____, hereby authorize the above named health care provider to give to, release, and permit copies to be made of all health care records that are in your possession.
2. The health care records should be disclosed to any authorized representative of West Bend Mutual Insurance Company. West Bend Mutual Insurance Company is the insurer for the employer and acts as its agent for insurance purposes.
3. The purpose of the disclosure of these records is to aid West Bend Mutual Insurance Company's evaluation of my claim.
4. West Bend Mutual Insurance Company may re-disclose my records to others retained by West Bend Mutual Insurance Company to assist in the evaluation of my claim, and thus, my records may no longer be private.
5. The type of information to be disclosed may include, but is not limited to, x-rays, x-ray reports, summaries, reports, narratives, test results, notes and any other health care records from all in-patient and out-patient visits at your institution or facility.
6. This authorization also permits release of all information relating to treatment for:
(a) drug and/or alcohol abuse;
(b) any mental disease, defect, or psychological/psychiatric condition;
(c) any communicable disease, AIDS, or AIDS-related disease.
7. I further authorize the provider to release any information in their possession and to meet with, discuss with, and/or to correspond and report directly to West Bend Mutual Insurance Company or any representative it may designate to discuss my medical and/or psychological condition(s) and/or treatment. These authorized communications may be initiated by the treatment provider. I also waive the right that I may have to be notified of these communications and to be present at consultations.
8. I understand that executing this authorization is a waiver of my privilege of physician-patient confidentiality, and I freely and voluntarily waive that privilege.
9. The above-named health care provider may not condition treatment, payment, enrollment or eligibility of benefits on obtaining your authorization.
10. A photocopy or facsimile of this authorization shall be valid and effective just as the original.
11. I understand that I may revoke this authorization, in writing to the records department of the above named health care provider, at any time, except where information has already been released as a result of this authorization.
12. Unless revoked, this authorization shall remain in effect for the period of one year beyond the date of patient's signature, or until my claim is closed, whichever is later. Records may be disclosed whether dated before or after the date of this authorization.
13. I understand that I or my authorized representative is entitled to receive a copy of the completed authorization form.

Signature of Patient/Guardian: _____ Date: _____

Social Security Number: _____ Birth Date: _____

Witness Signature: _____ Date: _____

Hand Coordination Activities (Check Appropriate Column)					
Movement Required	Tool/Machine		Right	Left	Both
Major hand					
Fine Manipulation					
Gross Manipulation					
Simple Grasping					
Power Grip					
Hand Twisting					
Pushing					
Pulling					
Tools Used By Worker			Weight	No. of Hands Needed To Move	
Objects Worker Must Move During Day			Weight	Distance	No. of Workers Needed To Move
Physical Surroundings Does Employee Work <input type="checkbox"/> Inside ___% <input type="checkbox"/> Outside ___%			Does Employee Walk On Uneven Ground? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does Employee Work Around Moving Machinery? <input type="checkbox"/> Yes <input type="checkbox"/> No			Does Employee Drive Automotive Equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, describe:					
Does the Employee Come In Contact With The Following? (Indicate Type)		Yes	No	Type	
Fumes					
Dust					
Mist					
Steam					
Strong Odors					
Poor Ventilation					
Air Conditioning					
Characteristics Of Job That Cannot Be Modified By Employer For This Employee					
Comments And/Or Observations					
<input type="checkbox"/> Job Site Evaluation Done			<input type="checkbox"/> Narrative Discussion Only		
Name(s) of Person(s) Interviewed			Title		
Person Completing Analysis		Title		Date	

ATTENDING PHYSICIAN'S RETURN TO WORK RECOMMENDATIONS RECORD

Claim No. _____

Patient's Name (First) _____

(Middle Initial) _____

(Last) _____

Date of Injury/Illness _____

TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE CHECK

Diagnosis/Condition (Brief Explanation)

I saw and treated this patient on _____ and based on the above description of the patient's current medical problem:
(date)

1. Recommend his/her return to work with no limitations on _____
(date)

2. He/She may return to work on _____ capable of performing the degree of work checked below with the following limitations: (date)

- Sedentary Work.** Lifting 10 pounds maximum and occasionally lifting and/or carrying such articles as dockets, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required only occasionally and other sedentary criteria are met.
- Light Work.** Lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, a job is in this category when it requires walking or standing to a significant degree or when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.
- Light Medium Work.** Lifting 30 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.
- Medium Work.** Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds.
- Medium Heavy Work.** Lifting 75-80 pounds maximum with frequent lifting and/or carrying of objects weighing up to 40 pounds.
- Heavy Work.** Lifting 100 pounds maximum with frequent lifting and/or carrying of objects weighing up to 50 pounds.

1. In an 8 hour work day patient may:
 - a. Stand/Walk
 None 1-4 hours 4-6 hours 6-8 hours
 - b. Sit
 1-3 hours 3-5 hours 5-8 hours
 - c. Drive
 1-3 hours 3-5 hours 5-8 hours
2. Patient may use hand(s) for repetitive:
 - Single Grasping
 - Pushing & Pulling
 - Fine Manipulation
3. Patient may use foot/feet for repetitive movement as in operating foot controls:
 - Yes No
4. Patient is able to:

	Frequently	Occasionally	Not At All
a. Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Instructions and/or Limitations Including Prescribed Medications:

These restrictions are in effect until _____ or until patient is re-evaluated on _____
(date) (date)

3. He/She is totally incapacitated at this time. Patient will be re-evaluated on _____
(date)

Physician's Signature _____

Date _____

RETURN TO WORK LOG

EMPLOYEE NAME _____ SUPERVISOR _____

Date	Hours Worked		Tasks Performed	Comments Regarding Employee's Tolerance of Modified Duty Tasks	Employee Initials	Supervisor's Initials
	In	Out				
Sunday / /						
Monday / /						
Tuesday / /						
Wednesday / /						
Thursday / /						
Friday / /						
Saturday / /						

I clearly understand, take responsibility for, and acknowledge the limitations my physician, Dr. _____ has placed on me while participating in this temporary transitional work program.

Employee Signature

Date

RETURN TO WORK LOG INFORMATION

The Return To Work Log is an efficient method used to monitor and document the specific tasks your employees are performing while on modified duty. It helps eliminate potential conflicts should the question arise regarding the employee performing work in excess of their restrictions.

- A supply of forms should be centrally located and provided to each department supervisor/manager.
- Attach a copy of the employee's restrictions to the log.
- Have employee write name on top of log and the Supervisor write their name.
- Remind employee it is their responsibility to follow the restrictions.
- Remind employee that the restrictions apply to occupational AND non-occupational activities.
- Employee and supervisor review all tasks completed each day, indicate any concerns and everyone signs the form.