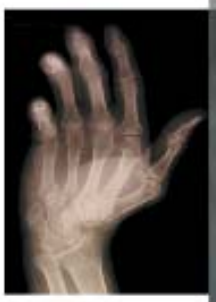
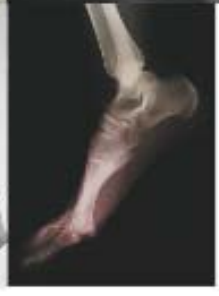
Return to Work for Small Business



A practical guide for employers and employees

Texas Mutual® Insurance Company



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Make Your Return-to-Work Process Fit Your Company

Whether you have just a few employees or a few hundred employees, your company will benefit by setting up a return-to-work process. The goal of any return-to-work process is to get an injured employee back to productive work as soon as medically reasonable.

The longer an injured employee stays off work, the less likely he or she will ever return to productive employment. On the other hand, employees who return to work quickly usually recover faster. Employers benefit from the return-to-work process because it minimizes lost productivity and other costs associated with workplace accidents.

Developing a return-to-work process for a small business can be challenging. Often, the most difficult aspect is putting the process in writing. That's why Texas Mutual Insurance Company created this guide. You can easily adapt the examples on the following pages to fit your company's needs.

If you have questions, contact your *Texas Mutual*® workers' compensation specialist or loss prevention consultant. **If you are preparing documents with legal implications, please consult your company's legal counsel**.

Remember the Basics

A return-to-work process includes three key parts: assessing job tasks, identifying modified duties, and making a bona fide offer of employment.

Assessing job tasks

Write down the separate activities or tasks involved in each job at your company. Include the physical demands (such as lifting, typing, standing) and the environmental conditions (such as vibration, noise, heat) in your descriptions.

Identifying modified duties

Use your task list to match the available work to the injured employee's work restrictions, as sanctioned by his or her treating doctor. Always tell the employee's doctor about the modified duties to make sure they meet the doctor's restrictions.

Making a bona fide offer of employment

If you can offer an injured employee modified duties that meet his or her doctor's restrictions, put the offer in writing. Tell your *Texas Mutual*® workers' compensation specialist whether the injured employee accepts the offer. If an injured employee refuses a bona fide offer of employment, the employee may lose his or her temporary income benefits.

Put It in Writing

On the following pages, we've provided sample documents to assist you with your return-to-work process. The descriptions below explain how to use each one. If you have questions about the documents or how to use them, call your *Texas Mutual*® loss prevention consultant or workers' compensation specialist.

Policy statement (Page 5)

Write a policy statement that confirms your commitment to the return-to-work process and explains the return-to-work philosophy. Your policy statement should stress the importance of safe operations, immediate medical care after an injury, and returning an injured employee to work as soon as is medically reasonable.

Employee responsibilities (Page 7)

Write procedures that explain the steps an injured employee will take from the time of injury until after the employee returns to work. Employees will understand the return-to-work process better and support it more fully if you include them in the development process.

Employee meeting sheet (Page 8)

Review the information on the policy statement, the procedures, and the medical contact information with all of your employees. Be sure all employees sign the sheet to verify that they attended the meeting and understand the process.

Physical demands task assessment (Page 9)

Use this form to describe physical demands and environmental conditions for each job at your company. Identify modified assignments to bring injured employees back to work.

Letter to doctor (Page 11)

A letter of introduction will explain that your company is willing to work with the doctor, the employee and the insurance company to provide alternative productive work (modified duty) that will meet the employee's work restrictions. Make arrangements with a doctor or clinic in your area for prompt medical care for your injured employees. If you have a *Texas Mutual*® policy that includes the *Texas Star Network*$_{SM}$ program, your injured employee must receive care from a network treating doctor. Visit the Health Care Network page at **texasmutual.com** for a list of network providers.

Release for medical information (Page 12)

Have injured employees take a medical information release form with them to the doctor. The doctor and the injured employee may keep a copy of the signed form for their records, and your company can keep the original signed form in its return-to-work file.

DWC-73, Work Status Report (Page 14)

Use this form to get the injured employee's medical restrictions as sanctioned by the treating doctor. NOTE: The Texas Department of Insurance, Division of Workers' Compensation (DWC) requires doctors to provide this form to employers.

Checklist for making a bona fide offer of employment (Page 16)
Make sure your offer meets DWC requirements. Use this checklist to verify that your offer complies with DWC rules.

Bona fide offer of employment letter (Page 17)
Send a bona fide offer of employment by certified mail to any injured employee who is able to return to work under doctor-sanctioned restrictions. If the injured employee does not speak or read English, contact your *Texas Mutual*® loss prevention consultant or workers' compensation specialist. They will have the offer translated for you.

Modified duty work agreement (Page 18)
Have the employee and the employee's supervisor (and return-to-work coordinator, if applicable) sign this form. The agreement states that the employer will not ask the injured employee to work outside of his or her medical restrictions.

Phone log (Page 20)
If an injured employee is physically unable to return to work, keep a phone log of all contact with the employee, the treating doctor and any other involved party. Include the times and dates of all contacts and attempted contacts. Maintain contact with the employee regardless of how long they are off work.

Contact Texas Mutual Insurance Company (Page 22)
If you have questions about creating or updating a return-to-work process for your business, contact a *Texas Mutual*® loss prevention consultant or workers' compensation specialist.

Sample Policy Statement for the Return-to-Work Process

(Company name) is committed to providing a safe and healthy workplace for our employees. Preventing injuries and illnesses is our primary objective.

If an employee is injured, we will use our return-to-work process to provide assistance. We will get immediate, appropriate medical attention for employees who are injured on the job, and we will attempt to create opportunities for them to return to safe, productive work as soon as medically reasonable.

Our ultimate goal is to return injured employees to their original jobs. If an injured employee is unable to perform all the tasks of the original job, we will make every effort to provide alternative productive work that meets the injured employee's capabilities.

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

President

Declaración Política del Proceso de Regreso al Trabajo

(Company name) se compromete a proporcionar un lugar de trabajo seguro y saludable para nuestros empleados. Nuestro objetivo principal es prevenir heridas y enfermedades.

Si un empleado se lastima, usaremos nuestro proceso de regreso al trabajo para proporcionar ayuda. Proporcionaremos atención médica apropiada inmediatamente para los empleados que se lastimen en el trabajo y crearemos oportunidades para que regresen a un trabajo seguro y productivo lo más pronto posible.

Nuestra meta principal es regresar a los empleados lastimados a sus trabajos originales. Si un empleado es incapaz de realizar todas las tareas de su trabajo original, haremos todo lo posible por proporcionar un trabajo alternativo que vaya de acuerdo con las capacidades del empleado lastimado.

El apoyo y participación de la gerencia y de todos los empleados es esencial para el éxito de nuestro proceso de regreso al trabajo.

Presidente

Sample of Employee Responsibilities Regarding Work-Related Injuries

You are responsible for working safely and following all safety rules.

If you are hurt on the job, you must report the injury immediately to your supervisor and go to the doctor that day for treatment, if necessary. We require drug testing after each work-related injury or illness.

Management is responsible for providing a safe work environment and for providing a smooth transition back to work for any employee who has experienced a work-related illness or injury.

We will encourage anyone who is off work due to a work-related injury or illness to return to work as soon as medically reasonable. We will provide modified work tasks as necessary.

We will work together to set guidelines for modified duty according to the doctor's restrictions.

It is essential that contact be maintained in order to promote your return to work. We care about your health, well-being and future with the company.

Procedures to follow after an incident:

- Report all incidents immediately, no matter how minor
- Complete an accident report
- Provide correct information immediately so that the DWC-1 form may be completed and filed within 24 hours
- Inform the physician that there is alternative productive work available
- Report to work on the next scheduled shift after you have been released by the doctor (either regular duties, modified duties, or reduced time)
- Perform only the jobs described by the doctor and manager, according to the doctor's restrictions
- Contact your manager weekly to discuss your restrictions and other return-to-work opportunities
- Verify that we have your current phone number and address

Failure to follow these procedures will result in disciplinary action according to the policies and procedures in the employee manual.

I have read and I understand all of the above policies, and I acknowledge my responsibilities.

Employee Signature:
Date:

Introduction to
The Return-to-Work Process

DATE: _____ TRAINER: _____

RETURN-TO-WORK PROCESS REVIEWED:

- Policy statement and benefits to the employees
- Procedures to follow after an injury
- Alternative productive work and bona fide offer of employment letter

EMPLOYEES IN ATTENDANCE:

NAME SIGNATURE

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

EMPLOYEES NOT IN ATTENDANCE DATE OF TRAINING

_____

_____

_____

_____

Physical Demands Task Assessment

Task title:_____ Date: _____ Analyst: _____

Task duration (hours/day): _____ With breaks: Yes / No Overtime (avg. hours/week):_____

Task description: _____

_____

_____

_____

_____

_____

_____

1. Postures:

Stand:	Hours at one time:	0	1/2	1	2	3	4	5	6	7	8	8+
	Total hours per day:	0	1/2	1	2	3	4	5	6	7	8	8+
Sit:	Hours at one time:	0	1/2	1	2	3	4	5	6	7	8	8+
	Total hours per day:	0	1/2	1	2	3	4	5	6	7	8	8+
Walk:	Hours at one time:	0	1/2	1	2	3	4	5	6	7	8	8+
	Total hours per day:	0	1/2	1	2	3	4	5	6	7	8	8+
Drive:	Hours at one time:	0	1/2	1	2	3	4	5	6	7	8	8+
	Total hours per day:	0	1/2	1	2	3	4	5	6	7	8	8+

2. Lifting/carrying

	Not present 0%	Occasionally 0-33%	Frequently 34-66%	Constantly 67-100%	Height of Lift	Distance of Carry
1-10 lbs	☐	☐	☐	☐	_____	_____
11-20 lbs	☐	☐	☐	☐	_____	_____
21-50 lbs	☐	☐	☐	☐	_____	_____
51-100 lbs	☐	☐	☐	☐	_____	_____
> 100 lbs	☐	☐	☐	☐	_____	_____

3. Actions and motions:

	Not present 0%	Occasionally 0-33%	Frequently 34-66%	Constantly 67-100%	Description
Pushing	☐	☐	☐	☐	_____
Pulling	☐	☐	☐	☐	_____
Climbing	☐	☐	☐	☐	_____
Balancing	☐	☐	☐	☐	_____
Bending	☐	☐	☐	☐	_____
Twisting	☐	☐	☐	☐	_____
Squatting	☐	☐	☐	☐	_____
Crawling	☐	☐	☐	☐	_____
Kneeling	☐	☐	☐	☐	_____
Reaching	☐	☐	☐	☐	_____
Handling	☐	☐	☐	☐	_____
Fingering	☐	☐	☐	☐	_____
Feeling	☐	☐	☐	☐	_____
Repetitive:					
hand motion	☐	☐	☐	☐	_____
foot motion	☐	☐	☐	☐	_____

4. Equipment:

	Not present 0%	Occasionally 0-33%	Frequently 34-66%	Constantly 67-100%	Description
Tools	☐	☐	☐	☐	_____
Machinery	☐	☐	☐	☐	_____
Equipment	☐	☐	☐	☐	_____

5. Environmental conditions:

	Not present 0%	Occasionally 0-33%	Frequently 34-66%	Constantly 67-100%	Description
Vibration	☐	☐	☐	☐	_____
Noise	☐	☐	☐	☐	_____
Extreme heat	☐	☐	☐	☐	_____
Extreme cold	☐	☐	☐	☐	_____
Wet/humid	☐	☐	☐	☐	_____
Moving parts	☐	☐	☐	☐	_____
Chemicals	☐	☐	☐	☐	_____
Electricity	☐	☐	☐	☐	_____
Radiation	☐	☐	☐	☐	_____
Other	☐	☐	☐		_____

Comments: _____

Letter for the Treating Doctor

(Date of letter)

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

Dear (Doctor's name):

(Company's name) has implemented a return-to-work process. This process is designed to return an injured employee to the workplace as soon as medically reasonable. The employees at (Company's name) are aware of our desire to provide alternative productive work in the event of an injury.

If one of our employees is unable to return to his/her original job, we will make every attempt to return this employee to modified duties. We will also ensure that this position meets with ALL medical restrictions that you prescribe. If necessary, we are willing to rearrange work schedules around diagnostic or treatment appointments.

Our company has identified job duties that may be suitable for a "return-to-work" situation. Please call me at (company's telephone number) if you have any questions about our return-to-work process or the alternative productive work available.

We would also appreciate updated information regarding the employee's status after each appointment. Thank you in advance for your participation in our efforts to return injured employees to a safe and productive workplace.

Sincerely,

(Company's representative)
(Title)
(Company name)

Medical Release of Information

Date

Claimant Name
Claimant Street Address

Claimant City, State, zip

Re: ***Claim No****:* ***_____;*** Request for the release of nonpublic personal information including personal health information.

Dear _____: (add name of claimant here)

_____ (the "Employer") is requesting release of your nonpublic personal information from the treating doctor to aid in the return-to-work process. This may include medical and other related information, as described in the attached authorization. The Employer is requesting your authorization to obtain this information.

Please read the attached authorization. It is valid for 24 months as written, but you may authorize the release of your nonpublic personal information for a lesser period of time on the authorization. Once you have signed this authorization, you may later revoke it at any time by writing to the Employer at _____(address), to the attention of _____(name).

Please sign and return the attached authorization to my attention at _____(address). Signing and returning the authorization will assist the Employer in the return-to-work process. Thank you in advance for your help in obtaining this information.

Sincerely,

_____ (*Name of Requestor*)

_____(*Title of Requestor*)

AUTHORIZATION FOR DISCLOSURE OF NONPUBLIC PERSONAL INFORMATION

Claimant's Name: _____

Claim No.: _____

By signing below, I, _____, (*claimant*) authorize my healthcare provider, their agents, employees or representatives, to release to _____ ("the Employer") for the return-to-work process, my medical records that include: physical therapy notes, information or medical opinions including diagnosis and prognosis, information on work status and activity restrictions, information regarding impairment and disability, and information regarding maximum medical improvement.

A copy or facsimile transmission (fax) of this Authorization is as valid as the original. This Authorization is effective on the date signed below and will remain in effect for 24 months after signing, unless otherwise specified below.

I also understand that I have the legal right to revoke this Authorization by writing to _____(the "Employer") at _____ (address), Attn: _____. If the Employer or a disclosing entity has already acted in reliance on my Authorization, my revocation will not apply to that action or transaction.

The potential exists that a recipient of nonpublic personal information might redisclose information used or disclosed pursuant to this Authorization, in which case medical and other privacy laws may no longer protect it.

With limited exceptions, treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned on obtaining an Authorization.

_____
Signature of Claimant or person legally authorized to act for Claimant

Please describe authority to act on behalf of Claimant_____

_____
Date Signed

___24 months_____
Time Authorization in Effect

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

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

TEXAS WORKERS' COMPENSATION WORK STATUS REPORT

PART I: GENERAL INFORMATION

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

PART II: WORK STATUS INFORMATION (FULLY COMPLETE ONE INCLUDING ESTIMATED DATES AND DESCRIPTION IN 13(c) AS APPLICABLE)

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

☐ (a) will allow the employee **to return to work** as of _____ (date) **without restrictions**.

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

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

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

14. POSTURE RESTRICTIONS (if any):

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

15. RESTRICTIONS SPECIFIC TO (if applicable):

☐ L Hand/Wrist ☐ R Hand/Wrist

☐ L Arm ☐ R Arm ☐ Neck

☐ L Leg ☐ R Leg ☐ Back

☐ L Foot/Ankle ☐ R Foot/Ankle

☐ Other: _____

17. MOTION RESTRICTIONS (if any):

Max Hours per day:	0	2	4	6	8	Other
Walking	☐	☐	☐	☐	☐	_____
Climbing stairs/ladders	☐	☐	☐	☐	☐	_____
Grasping/Squeezing	☐	☐	☐	☐	☐	_____
Wrist flexion/extension	☐	☐	☐	☐	☐	_____
Reaching	☐	☐	☐	☐	☐	_____
Overhead Reaching	☐	☐	☐	☐	☐	_____
Keyboarding	☐	☐	☐	☐	☐	_____
Other: _____	☐	☐	☐	☐	☐	_____

18. LIFT/CARRY RESTRICTIONS (if any):

☐ May not lift/carry objects more than ____lbs. for more than ____ hours per day

☐ May not perform any lifting/carrying

☐ Other:_____

19. MISC. RESTRICTIONS (if any):

☐ Max hours per day of work: _____

☐ Sit/Stretch breaks of _____ per _____

☐ Must wear splint/cast at work

☐ Must use crutches at all times

☐ No driving/operating heavy equipment

☐ Can only drive automatic transmission

☐ No work / ☐ _____hours/day work:

☐ in extreme hot/cold environments

☐ at heights or on scaffolding

☐ Must keep _____:

☐ Elevated ☐ Clean & Dry

☐ No skin contact with: _____

☐ Dressing changes necessary at work

☐ No Running

16. OTHER RESTRICTIONS (if any):

20. MEDICATION RESTRICTIONS (if any):

☐ Must take prescription medication(s)

☐ Advised to take over-the-counter meds

☐ Medication may make drowsy (possible Safety/driving issues)

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

PART IV: TREATMENT/FOLLOW-UP APPOINTMENT INFORMATION

21. Work Injury Diagnosis Information:

_____

_____

22. Expected Follow-up Services Include:

☐ Evaluation by the treating doctor on _____ (date) at ____ : ____ am/pm

☐ Referral to/Consult with_____ on _____ (date) at ____ : ____ am/pm

☐ Physical medicine __ X per week for __ weeks starting on _____ (date) at ____ : ____ am/pm

☐ Special studies (list): _____ on _____ (date) at ____ : ____ am/pm

☐ None. This is the last scheduled visit for this problem. At this time, no further medical care is anticipated.

Date / Time of Visit	EMPLOYEE'S SIGNATURE	DOCTOR'S SIGNATURE	Visit Type:	Role of Doctor:
_____ Discharge Time			☐ Initial ☐ Follow-up	☐ Designated doctor ☐ Carrier-selected RME ☐ DWC-selected RME ☐ Treating doctor ☐ Referral doctor ☐ Consulting doctor ☐ Other doctor

DIVISION OF WORKERS' COMPENSATION

DWC FORM - 73
WORK STATUS REPORT INSTRUCTIONS

PART I: GENERAL INFORMATION - Contains space to record general information about the employee and the doctor/clinic. This section includes space to record a high-level generic description of the injury or condition (e.g. broken right arm, strained left knee, etc) and how it occurred. Also contains space to record the name and facsimile number or email address of the insurance carrier (carrier) and the employer, as well as the date of transmission. This space is intended to eliminate the need for a separate facsimile cover page. **Because this information is intended primarily for transmission purposes, the report may be provided to the injured employee (employee) at the time of the examination, even if the information required in this section is not yet available.**

PART II: WORK STATUS INFORMATION - The doctor is required to indicate the employee's current work status. There are three choices: able to work without restrictions; able to work with restrictions; and prevented from returning to work.

If the doctor believes that the employee can only work with restrictions or is prevented from returning to work, the doctor is **required** to provide an estimated date of expiration for the restrictions. These estimates are required to enhance claims management and to provide the employer with information that can be used to plan work coverage and plan for the employee's return to work (whether with or without restrictions). **An estimated expiration is speculative in nature. The further the date is projected, the less accurate it may be. Estimations are not binding and may be changed as needed based upon the condition and progress of the employee by filing a subsequent Work Status Report. Doctors need to provide reasonable estimates based upon the nature of the employee's injury.**

In addition, a doctor who believes that an employee is prevented from returning to work is required to provide a specific explanation of how the condition prevents the employee from returning to work. One of the goals of the Texas Workers' Compensation Act is to ensure a speedy return to employment which is safe, meaningful, and commensurate with the abilities of the employee. **It is the responsibility of the doctor treating or examining an injured employee to identify what the employee may be able to safely perform. It is not the doctor's responsibility to ensure that the employer has a modified duty position that meets those restrictions - that is the employer's responsibility if the employer chooses to try to accommodate the restrictions.**

PART III: ACTIVITY RESTRICTIONS - If the doctor indicates that the employee is able to work with restrictions, the doctor is to indicate those restrictions in this section. **The doctor is only supposed to indicate what restrictions are in place because of the workers' compensation injury.** Any restrictions that may have existed due to other conditions are assumed to remain and should not be duplicated here. The doctor should go over the restrictions with the employee at the time the report is provided.

The section was designed to include check boxes for common restrictions that may apply to the employee. If a box is not checked, it is assumed that there is no restriction on that activity. Also, if no specific body part is indicated in box #15, then it should be understood that the restrictions are whole body restrictions.

PART IV: DIAGNOSIS/FOLLOW-UP INFORMATION - Provides general diagnosis information and provides upcoming appointment information (if known at time of filing report) so that the carrier can better manage the claim and the employer can be aware of time where the employee might not be available for work. In addition, providing this information may reduce calls from carriers and employers seeking the information. **However, doctors need ensure that the diagnosis information provided to the employer is at a general level and does not violate any confidentiality laws relating to the employee's privacy rights.**

The Work Status Report is primarily designed to be filed by the treating or referral doctor. However, other doctors can and will occasionally need to file this report. The following describes the various roles that doctors can play within the system:

***Treating*:** Doctor chosen by and primarily responsible for employee's injury-related health care.	***Referral*:** Doctor who was selected by the treating doctor to treat one or more aspects of the employee's medical condition.
Consulting: Doctor who was selected by the treating doctor to provide an opinion on the employee's medical condition.	***Carrier-selected RME:*** Doctor selected by the insurance carrier.
***Designated*:** Doctor selected by the Division to evaluate whether the employee's medical condition has improved sufficiently to allow a return to work (only for Supplemental Income Benefits claims).	***DWC-selected RME:*** Doctor selected by DWC.
	Other: Doctor who fits none of the other descriptions.

Basic Instructions - Provide to injured employee at time of examination and fax or electronically transmit to: insurance carrier and employer by the end of the second working day following the date of the examination. Report must be filed after initial visit, when there is a change in work status or a substantial change in activity restrictions, and on the schedule requested by or through the carrier (not to exceed one report every two weeks). Also file within 7 days of receiving functional job descriptions from the employer or a Work Status Report from a Required Medical Examination doctor that indicates that the employee is able to return to work with or without restrictions.

Rules 126.6, 129.5, and 130.110 lay out the complete requirements for filing this report (in addition, Rule 129.6 provides information on how the report might be used). The complete text to these rules is available on the Division's web site at www.tdi.state.tx.us.

Checklist for Making a Bona Fide Offer of Employment

When the treating doctor releases an injured employee to return to work in any capacity, you should make a bona fide (valid) offer of employment to the employee. Making a bona fide offer of employment may affect the employee's income benefits, so we must consider the following information (from DWC Rule 129.6) before we can determine whether an offer is bona fide.

- Did you include a written copy of the Work Status Report (DWC-73) with the offer?
- Is the offer for a job at a geographically accessible location for the employee?
- Is the job consistent with the doctor's certification of the employee's physical abilities?
- Did you communicate the offer to the employee in writing?

We have provided a sample letter on the following page to help you make a bona fide offer. Before you make an offer, you may want to call us and ask for assistance. We can help if you have questions or need additional information. Follow this checklist when you write your own offer:

- ☐ Include a copy of the Work Status Report (DWC-73) with the offer.
- ☐ State the location at which the employee will be working.
- ☐ Indicate the schedule the employee will be working.
- ☐ State the wages that the employee will be paid.
- ☐ Give a description of the physical and time requirements that the position will entail.
- ☐ Include a statement indicating that you, as the employer, will only assign tasks consistent with the employee's physical abilities, knowledge and skills, and that you will provide training, if necessary.

Remember: By making the offer in writing (and keeping a copy for your records), you will be able to prove that you made a bona fide offer of employment in accordance with DWC's requirements, should the need arise. Without a written offer on file, DWC could require the carrier (Texas Mutual Insurance Co.) and/or the employer (you) to provide "clear and convincing evidence" that you actually made the bona fide offer of employment to the employee.

For more information on bona fide offers of employment, call us at (800) 859-5995 or visit our website at **www.texasmutual.com**.

Sample Bona Fide Offer of Employment

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Date

Injured Employee
Address
Texas, Texas 70000

Dear _____:

(Company's name) would like to offer you a temporary, modified-duty job assignment at our main assembly plant at ***location.*** The schedule for this position is from ***hours and days of week***, and the job pays ***wages per hour***. The job duties meet the work restrictions sanctioned by ***doctor's name*** (see enclosed work status report).

Write a paragraph that describes the job duties, physical limitations, maximum physical requirements, and time requirements.

While you are working in this modified-duty job assignment, we will only assign tasks that are consistent with your physical abilities, knowledge, skills, and work restrictions as sanctioned by (doctor's name). ***We will provide training, if necessary.***

Please contact me by ***day and date*** at (phone number) if you are willing to accept this offer of a temporary, modified-duty job assignment.

Sincerely,

Name, Title
Company

Enclosed: DWC-73, Work Status Report from (doctor's name)

Sample Modified Duty Work Agreement

Employee's name: _____ Department: _____

Employee's title: _____ Date: _____

My work duties are changed from_____(date) until_____ (date). I am assigned to modified work duties or limited duties. My new work duties are listed below.

_____

_____

_____

_____

The duties above have been described to my doctor. My doctor has signed Form DWC-73 stating that I may do these activities under the following medical restrictions.

_____

_____

_____

I agree to do the above work duties and follow my doctor's medical restrictions. If I ignore my medical restrictions, I understand that my employer may take disciplinary action.

If a supervisor or anyone else asks me to do work assignments or activities that don't follow my medical restrictions, I must immediately report the situation to _____ (name of return-to-work coordinator), who will take action to correct the situation.

If I think my new work duties are causing discomfort or making my medical condition worse, I will report this immediately to _____ (name of return-to-work coordinator).

Employee signature: _____ Date: _____

Supervisor signature:_____ Date: _____

Return-to-work coordinator signature: _____ Date: _____

Muestra de un Acuerdo de Trabajo Alternativo
(Sample Modified Duty Work Agreement)

Nombre del empleado: _____ Departamento: _____

Puesto del empleado:_____ Fecha: _____

Mis deberes de trabajo han cambiado de_____ (fecha) al _____ (fecha). Estoy asignado a los deberes de trabajo alternativos o limitados. Mis deberes de trabajo nuevos están listados en la parte inferior.

_____

_____

_____

Los deberes descritos en la parte superior han sido explicados a mi doctor. Mi doctor ha firmado una Form DWC-73 estableciendo que yo puedo realizar estas actividades bajo las siguientes restricciones médicas.

_____

_____

Acepto los deberes de trabajo listados en la parte superior y seguir las restricciones del doctor. Si ignoro mis restricciones médicas, entiendo que la compañía para la que trabajo puede tomar acciones disciplinarias.

Si un supervisor o cualquier otra persona me pide que haga tareas o actividades que no cumplan con mis restricciones médicas, debo reportar la situación inmediatamente a _____ (nombre del coordinador del regreso al trabajo), quien corregirá la situación.

Si pienso que mis nuevos deberes de trabajo están causando incomodidad o están empeorando mi condición médica, lo reportaré inmediatamente a_____ (nombre del coordinador del regreso al trabajo).

Firma del empleado: _____ Fecha: _____

Firma del supervisor:_____ Fecha: _____

Firma del coordinador del regreso al trabajo: _____ __Fecha:_____

After-Injury Telephone Report

Employee's name: _____

Home phone: _____

Employee's supervisor: _____

Date of injury: _____

Treating doctor: _____

Doctor's phone: _____

Have workers' compensation benefits been discussed with employee? Yes No

Has the return-to-work process been discussed with employee? Yes No

Log of Doctor's Appointments

Date:
Time:
Comments:
Contact by:

Date:
Time:
Comments:
Contact by:

Date:
Time:
Comments:
Contact by:

Supervisor's Telephone Log

Date	Time	Comments

How to Contact Us

Main number
(800) 859-5995

Claim reporting
Online www.texasmutual.com
Phone (800) TX-CLAIM (892-5246)
Fax (877) 404-7999

Claim information
(800) 859-5995

Loss prevention
(512) 505-6042

Texas Mutual Insurance Company
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Austin, TX 78723-1098
www.texasmutual.com

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