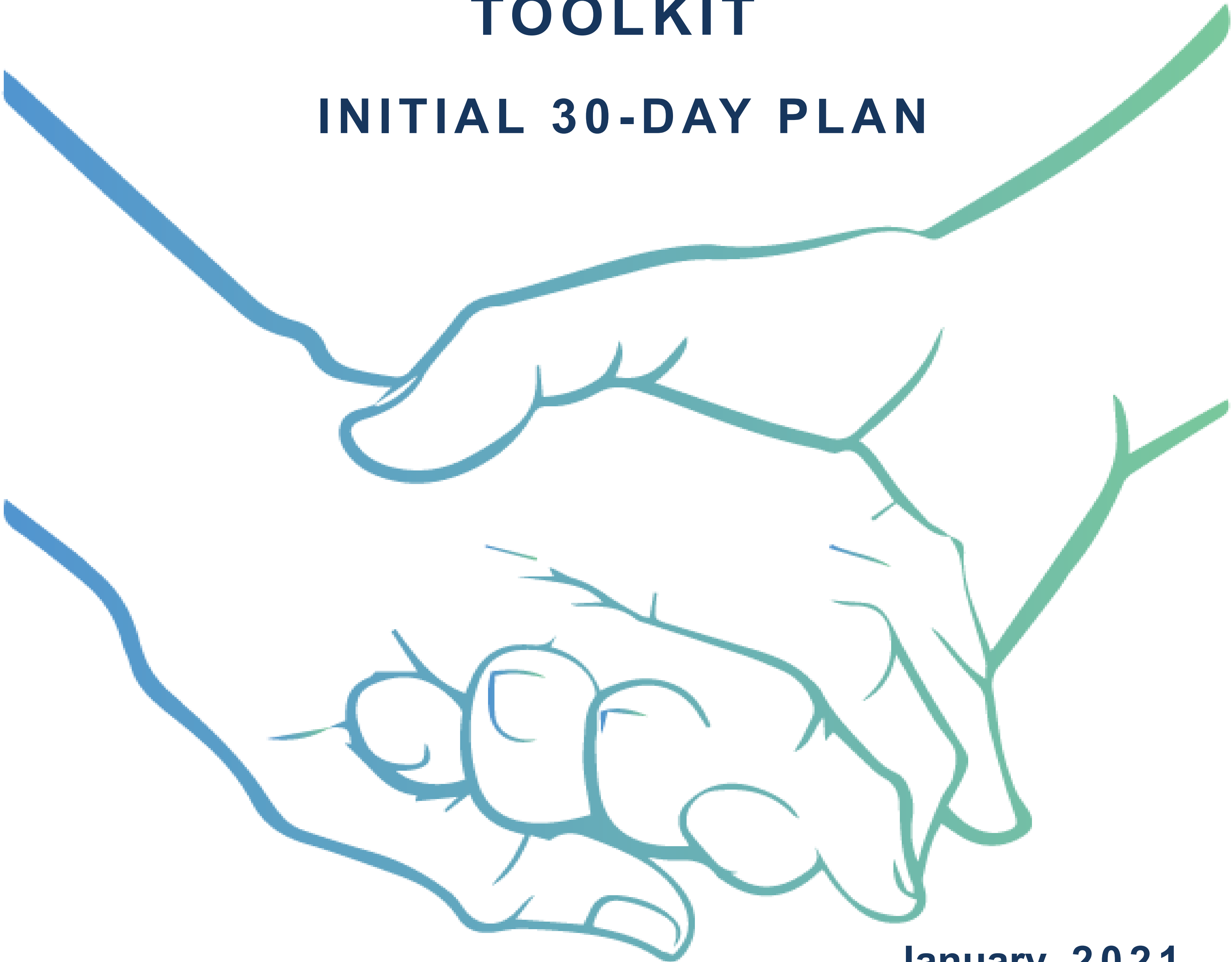
DAS
DEPARTMENT OF ADMINISTRATIVE SERVICES

EARLY RETURN-TO-WORK (ERTW) TOOLKIT

INITIAL 30-DAY PLAN



January 2021

Welcome!

This toolbox has been designed for your use. The content has been reviewed by experts who work in state government and SAIF Corporation. The resource is meant to fit the unique needs of your agency. DAS Risk Management is available to assist you in making any modifications that you feel are necessary to meet the unique characteristics of your agency. Please contact DAS Risk Management by calling 503-373-7475 or send an email to: risk.management@oregon.gov.

Purpose: Provide a simple approach for managers/supervisors regarding returning an injured worker to work following an on-the-job injury.

Duration: Intended for use from the first notification that the worker had an incident/accident while working through at least the first 30-day review period.

Best Practices

Communicating expectations to all injured workers and their role in the process regarding Early Return-to-Work expectations is important to the success of any Agency returning an injured worker to work. The communications avenues are many and should happen often. The earlier communication occurs the better; this should be part of the new employee orientation. For managers/supervisors new to the position this should be a conversation where resources and expectations are outlined within the first 30-days of the new management assignment.

Developing a transitional/modified duty assignment should not be overwhelming. The goal would be to have a worker back to work within three calendar days from the date of injury. Review the medical restrictions provided by the medical provider and follow the steps below:

1. Can the worker still perform their regular job? If yes, then have worker perform regular work.
2. If no, then can you modify portions of the worker's regular job to fit the medical restrictions provided? If yes, then have the worker perform the modified regular work. Be clear with the worker about not exceeding the restrictions provided by the medical provider.
3. If you are not able to modify the worker's regular job then provide the worker with other available work that meets the medical restriction requirements (and any applicable collective bargaining agreement requirements or considerations). Again be clear with the worker that they should not exceed any physical restrictions provided by the medical provider.
4. If you are not able to provide the worker with any other available work within your own agency, you can reach out to DAS CHRO for assistance in seeking available Intra-agency work with an agency who may have locations near the injured workers duty station. If you already know of other agencies that have locations near the injured workers' duty station, and potential work available that would meet the injured workers' restrictions, then you can also reach out to their Safety Manager or Human Resources office directly, without contacting DAS CHRO. (*Please consider whether or not your agency's funding sources will allow for this type of intra-agency arrangement*.)

The injured worker should transition back to their regular work as soon as medically possible. This tool is meant to assist you through at least the first 30-days of this process.

Resources:

- Agency's Workers' Compensation Coordinator
- Agency's Safety Manager/Specialist
- Agency's Human Resources Manager or Analyst
- DAS/Risk Management Consultants
- SAIF Corporation Return-to-work consultant (State Agency Team)
- SAIF Corporation Claims Adjuster (State Agency Team)

Policy & Statute References:

- Early Return to Work of Injured Workers
  - HR Policy 50.020.05
- Injured Worker Preference for Light Duty Assignments Rule
  - OAR 105-050-0025
- Injured Worker Preference for Entry-Level Positions Rule
  - OAR 105-050-0030
- Reemployment/Reinstatement
  - HR Policy 50.020.03
- Family & Medical Leave (FMLA)
  - HR Policy 60.000.15
- Americans with Disabilities Act (ADA)
  - HR Policy 50.020.10
- Continuation of Benefits for Injured Workers' (CBIW) Statute
  - ORS 659A.060-659A.069
- Workers' Compensation - Labor, Employment; Unlawful Discrimination
  - ORS 656.005-656.340
- State Agency General Records Retention Schedules
  - OAR 166-300-0010 through 0045.

***Incident/Accident Occurs.**

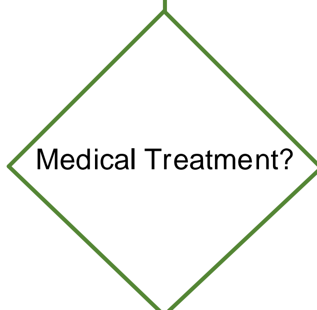
Early Return to Work Process

Employee reports an incident/accident to manager/supervisor.

Agency Incident/Accident report form is completed by injured worker & manager/ supervisor.

Injured worker and manager/supervisor analyze incident to determine potential ways to prevent reoccurrence of the event.

Send copy to Safety Committee with employee information removed.



No

Retain a copy of the Incident/Accident report form in employee's file. (not personnel file)

*If an injured worker provides a RTW form, but a manager/supervisor is unable to provide transitional/modified duties within their work unit, please refer to page 2 of this Flow Chart.

Yes

Manager/supervisor reviews injured worker rights/responsibilities with worker.

Complete Workers' Compensation Claim Form 801.

Send to SAIF Corporation to 1-800-475-7785. Submit within 5 days of Injury.

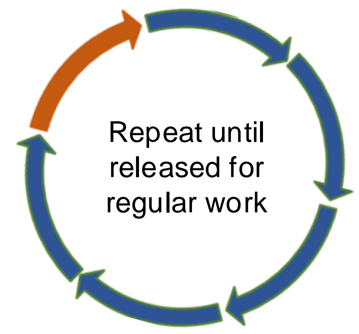
Injured worker brings Release to Return-to-Work (RTW) form to medical provider.

Worker brings completed RTW form to manager/supervisor*

Worker released to return to regular work with no restrictions.

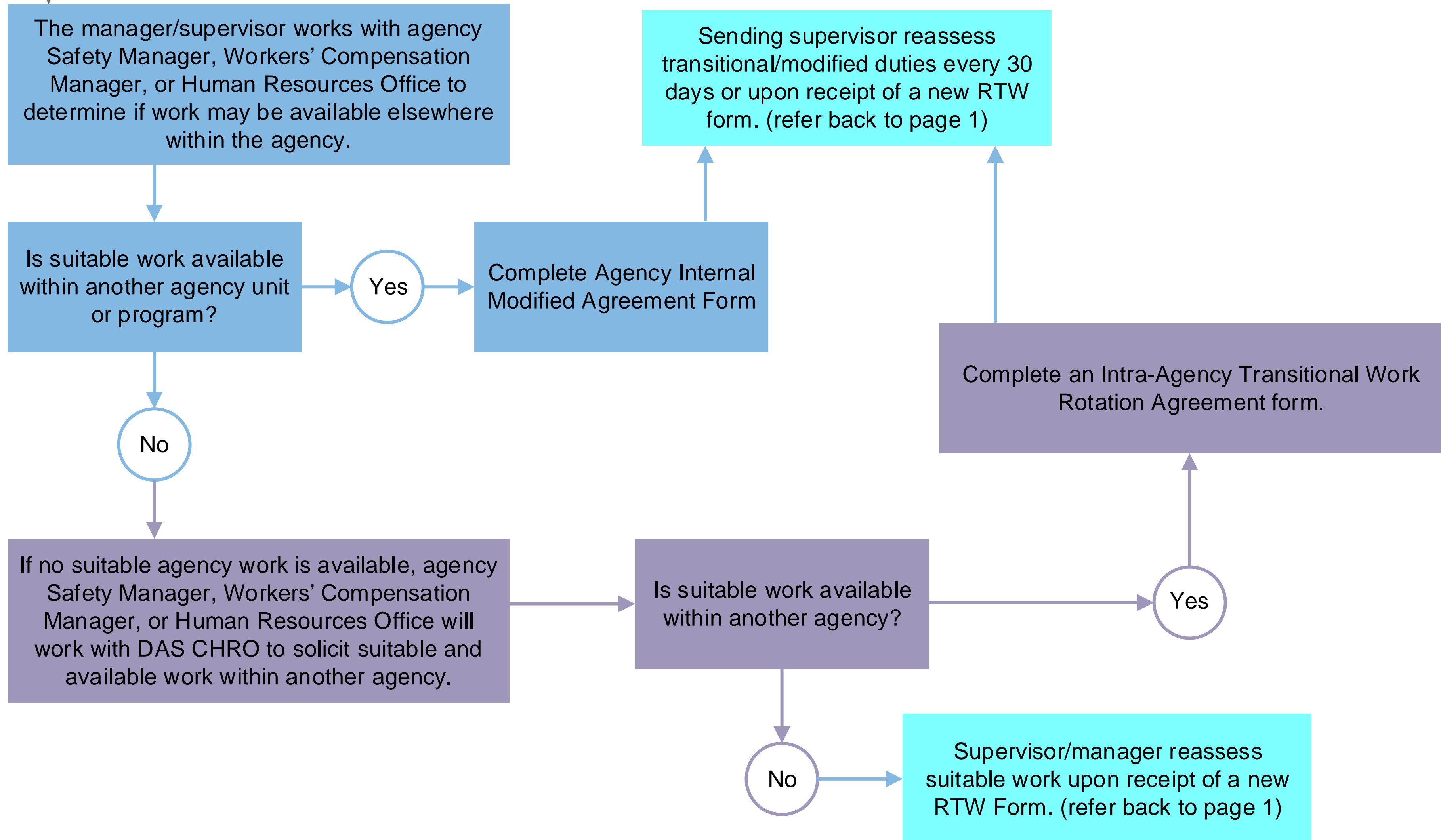
Manager/supervisor returns worker to work within restrictions.

Worker is not released to return to any work.



Injured worker brings RTW form to follow up appointment with their medical provider.

Note: Please refer to DAS policy Early Return to Work of Injured Workers (50-020-05) for additional requirements and review the States Record Retention Schedule requirements detailed in OAR 166.300-0010 through 166.300-0045 to determine how long to retain an employees Incident/Accident related documents.



Note: Please consider whether or not your agency's funding sources will allow for this type of arrangement with another agency. (Ex. Federal grant requiring specific work to be completed by a specific agency for eligibility of reimbursement.)

DAS DEPARTMENT OF ADMINISTRATIVE SERVICES

Statewide HR Policy

SUBJECT:	Early Return to Work of Injured Workers	**NUMBER:**	50.020.05
DIVISION:	Chief Human Resource Office	**EFFECTIVE DATE:**	**06/12/2020**

APPROVED: Signature on file with the Chief Human Resources Office

POLICY STATEMENT: Oregon state government as an employer through its agencies and partners will develop and implement an Early Return to Work Program for injured workers that effectively reduces medical, disability, premium costs, and positively impacts employee recovery from work-related illnesses and injuries.

AUTHORITY: 240.145; 659A.043; 659A.046; 659A.052; OAR 105-050-0025

APPLICABILITY: All injured workers, where not in conflict with an applicable collective bargaining agreement

ATTACHMENTS:

DEFINITIONS: Also refer to HR Policy 10.000.01, Definitions; HR Policy 50.020.03 Reinstatement and Reemployment of Injured Workers

POLICY

(1) Agencies shall develop, implement, and maintain an Early Return to Work Program that will:
- (a) Strive to return an injured worker to a transitional assignment that complies with medical limitations within three days of being released to transitional work.
- (b) Provide a written offer of temporary transitional work notifying the worker of their responsibilities including but not limited to:
  - (A) The temporary nature of the transitional work assignment and reevaluation process.
  - (B) Description of job duties based on the injured worker's physical restrictions.
  - (C) Physical work restrictions and limitations relevant to the assignment to be approved by the attending physician.
  - (D) Potential loss of reemployment and reinstatement rights of failing to accept a bona fide offer of transitional work [see HR Policy 50.020.03(1)(e)(C)(iv)].
- (c) Effectively review transitional work assignments every thirty days or sooner if needed in order to adjust the work assignment to align with the worker's temporary work restrictions and monitor the injured worker's recovery.
- (d) Limit transitional work to four, thirty-day review sequences unless there are extenuating factors based on written medical confirmation of the worker's prognosis with an expected recovery date that justifies continuing the transitional work assignments. Otherwise end transitional work assignments when one of the following occur:
  - (A) The injured worker is released by the attending physician to regular work.

(B) The attending physician determines the employee to be medically stationary with permanent restrictions or releases the employee to suitable employment.
(C) The injured worker fails to abide by medical restrictions or terms of the transitional work assignment.
(D) The transitional work assignment can no longer be provided by the agency.
(E) The workers' compensation claim is denied by the insurer.

(e) Utilize to the fullest extent possible, the Employer-at-Injury Program and Preferred Worker Programs administered by the Department of Consumer & Business Services, Workers' Compensation Division for the purposes of wage subsidy, worksite modification and reimbursement for related purchases.

(2) During the Early Return to Work period, the agency will:
(a) Work with SAIF and DAS Risk Management to coordinate injured worker management and claim resolution.
(b) Communicate as needed with SAIF Claims Team, DAS Risk Management, DAS Chief Human Resources Office, Agency Benefits Managers, and the Department of Justice.
(c) Coordinate leave laws, bargaining agreements, injured worker/workers compensation laws and rules.

(3) If the agency-at-injury cannot find transitional work within itself for the injured worker, the agency-at-injury may contact the Chief Human Resources Office (CHRO) or other executive branch agencies for assistance in locating transitional work assignments. The following stipulations apply:
(a) The injured worker remains the employee of the agency-at-injury.
(b) All BOLI reinstatement reemployment rights remain with the agency-at-injury.
(c) All other aspects of this policy still apply.

Please refer to the toolkit associated with this policy for additional clarifying information.

Manager/Supervisor Responsibilities & Instructions

- ☐ Review the "injured worker rights and responsibilities" form with the injured worker.
  - Make sure they sign the document.
  - Maintain a copy for file.
  - Send a copy to: ____________________.

- ☐ Complete the workplace "incident/accident" form. Conduct an analysis as quickly as possible and correct any hazards found, or engage your Safety Manager and/or safety committee with this process.
  - Send the safety committee a copy with injured worker's information removed.
  - Send a copy to: _______________________.

- ☐ If the worker is not going to seek medical treatment, **stop here.**

- ☐ If the injured worker has or will be seeking medical treatment, then; have the injured worker complete the "employee" section of the Workers' Compensation Claim, form 801. Work with Safety/Workers Compensation or HR resources to complete the remainder of the form. Make sure the form is completed and submitted to SAIF Corporation within 5 calendar days of the accident/incident.

- ☐ Provide the injured worker with the "Release to Return-to-Work" form and remind them that their medical provider needs to complete the form following each medical visit. The worker needs to return it to you after each visit. (While a provider is not required to use the agency's form, a descriptive work release in one form or another detailing the injured worker's restrictions or full duty release is needed from the medical provider).

- ☐ Have the injured worker read the "CBIW Notification Form", initial and sign where indicated.
  - Make sure the injured worker knows that they are still responsible to pay their portion of the insurance to maintain coverage.
  - Maintain a copy for file.
  - Send signed copy to HR to be retained by the benefits coordinator.
  - In some cases, an extension to the CBIW can occur under the Affordable Care Act. Direct your injured worker to contact your Payroll department for more information on their eligibility.

- ☐ Provide the injured worker a copy of Reemployment/Reinstatement HR Policy 50.020.03

- ☐ Have the injured worker read and complete the "Designation of Leave" form.
  - Send completed form to the payroll unit.
  - Maintain a copy for file.
- ☐ Payment of time loss
  The injured worker may be compensated by SAIF Corporation for the days missed from their job when they have filed a workers' compensation claim. The absence must be authorized in writing by their Physician in order for the injured worker to receive time loss payments. The first three (3) calendar days after leaving work are considered a "waiting period" and are not compensated unless the injured worker is authorized to be off work for 14 consecutive days or longer, or immediately hospitalized. Time loss compensation is paid directly by SAIF Corporation. If

reimbursement of the 3 day wait is determined by SAIF, it may not be immediately paid, but will be adjusted at claim closure. Time loss payments equal approximately 66 2/3 % (percent) of regular pay, up to the Oregon average weekly wage and are not taxable. The injured worker is NOT entitled to compensation from both agency payroll and SAIF time loss payments that would exceed their normal wages.

☐ Use of Leave for on-the-job injury or illness
While awaiting a decision by SAIF Corporation, regarding compensability of a workers' compensation claim, an applicable collective bargaining agreement may determine which types of leave the injured worker is required to use. If receiving payment from SAIF Corporation, the injured worker must use leave without pay for anytime being paid by SAIF Corporation. They may elect to use accrued leave to supplement the SAIF Corporation payment. If the injured worker wishes to supplement the amount paid by SAIF Corporation with accrued leave code time as follows, for an 8 hour day: (Always consult with your payroll unit for proper coding of leave usage.)

Code	Hours
SLG/SL3, PB, VAG/VA3 or Comp (Any of the above can be used.)	2.66 hours
LOG/LO3	5.34 hours

For questions about coding, please contact the Payroll Unit at: ______________.

☐ Reporting absences in the payroll system
Absences which are related to your workers' compensation claim must be reported in the agency payroll system using the appropriate leave codes associated with a SAIF claim, do help designate workers' compensation leave with other absences. If no accrued leave is available, a request for a LEAVE OF ABSENCE must be submitted along with the doctor's statement authorizing the absence from work. The injured worker's injury may also qualify under FMLA. Contact your HR office to confirm determination of the injured worker's eligibility.

☐ Maintain contact weekly with the injured worker and your agency Safety/Workers Compensation or Human Resources. **Ensure that their contact information is/remains up-to-date in Workday.**

☐ **If the injured worker is released to Modified/Transitional work**, find modified/transitional work for injured worker. (If you are unable to adapt the injured worker's current position to the medically documented restrictions, please notify Safety or Human Resources immediately.)

Injured Worker's Rights and Responsibilities

☐ Report all incidents and injuries to your manager/supervisor immediately and no later than 24 hours from the event, if possible. **Do this even if no one is injured.**

☐ Assist your manager/supervisor in completing an accident/incident report and an analysis of the events.

If you seek or are going to obtain medical treatment (i.e. ER visit, urgent care or doctor's office) for work-related injury or illness, please complete the following:

☐ Complete and sign the worker section of the Workers Compensation Claim, form 801, and give this to your manager/supervisor.

☐ If you are unable to complete the 801 form, please provide your manager/supervisor with the following information, as soon as possible:

a. Time and date of injury;
b. Brief description of your injury;
c. Your return-to-work status;
d. The name, address and phone number of your treating physician.

☐ Present a "release to return-to-work" form to your medical provider for completion during each visit. Provide the completed document or other release from the medical provider to your manager/supervisor the next business day, or sooner, following your medical evaluation.

- Work with your manager/supervisor if any modified/transitional work assignment is necessary;
- Do not work beyond the physical restrictions provided by your medical provider;
- You will receive regular wages and benefits for modified/transitional work. The assignment will last until any of the following occur:
  - 30-day review, or sooner, indicates you are not improving;
  - 120 days have elapsed from the start of your modified/transitional work;
  - Your medical provider indicates you have permanent restrictions that will prevent you from returning to your regular job;
  - Modified/transitional work is no longer available;
  - Your medical provider released you for regular work;
  - Your claim for workers' compensation benefits is denied.

If you are not released for regular or modified/transitional work:

☐ Maintain regular contact with your supervisor as agreed to, but at least weekly.

☐ Provide a completed "release to return-to-work" form to your manager/supervisor following each medical evaluation.

☐ Present any information regarding your return-to-work status from your medical provider to your manager/supervisor.

- ☐ At all times, provide a current address or phone number for how you may be contacted.

For information regarding your claim, contact SAIF Corporation at 503-373-8000 or 800-285-8525. Have your SAIF Corporation claim number available. If you have a question regarding your employment, contact you manager/supervisor or your agency's Human Resource office.

I have read the information provided. I understand my responsibilities. I will call all appropriate parties to obtain more information or clarify any questions that I have.

Employee Signature Date

Manager/Supervisor Signature Date

ERTW Toolkit Letters

EARLY-RETURN-TO-WORK PROGRAM: DAY ONE MEMO

TO:

FROM:

SUBJECT: TEMPORARY MODIFIED/TRANSITIONAL – DUTY ASSIGNMENT
DAY ONE:

I am pleased we are able to offer you this temporary modified/transitional-duty assignment during your recovery.

The tasks assigned are based on your physician's medically documented restrictions. You should not at any time exceed your medical restrictions and/or any hour limitations. If you feel you are being asked to do so, contact immediately.

This temporary modified/transitional-duty assignment will be reviewed as we receive updates to your restrictions from your physician, and at a minimum after 30 consecutive calendar days starting on Day One noted above.

However, if you are not released to your regular job within 30 days but you are progressing toward recovery, this temporary assignment may be extended for a limited time. But if your doctor documents that you will be unable to return to your regular job because of permanent medical restrictions, we must consider other employment options for you. Therefore, it is important that you, your doctor, and I remain in regular contact with regard to your progress toward recovery. In the event that you may not be able to return to your regular job, you should notify immediately. Other employment options or benefit opportunities can be explored.

We look forward to your return to your regular assignment.

If you have any questions, call

I have read and understand the above information.

______________________________ ______________________
Employee Signature Date

Copy to: Employee, Personnel,
Original to SAIF employee file

RE:

Dear Dr.

Thank you for your prompt treatment of our employee, We want you to know that has a well-developed return-to-work policy. We can provide a variety of modified/transitional tasks while our employee is recovering from a work related injury. will continue to receive the same wage and benefits while working in this temporary modified/transitional assignment.

	We would appreciate your assistance by completing the enclosed Release to Return to Work form, which will help us identify appropriate job tasks.
	We would appreciate your assistance by completing the enclosed Release to Return to Work form and reviewing the attached (modified/transitional job description/analysis) for your approval.
	We would appreciate your assistance by reviewing the attached (modified/transitional job description/job analysis) for your approval.

With regular updates, our agency is usually able to continue early return to work temporary assignments while our employee progresses toward return to their regular job.

If you have any questions, feel free to contact me at the number below.

Regards,

Enclosure

Date: ________________________

Name of Employee: ____
Address: ____
City, State, Zip: ____

SAIF Claim Number: ____________________
Date of Injury: _________________________

Dear _________________________:

Your attending physician has released you for modified work. We have developed a temporary light duty job within the physical restrictions outlined by your doctor. Your doctor has reviewed and approved a description of the light duty job (see enclosed job description). The duration of this light duty position will be periodically re-evaluated.

Job title:	
Wage: $ per	**Report to:**
Start date:	**Start time:**
Hours per day:	**Days per week:**
Location:	**Duration, if known:**

Upon receipt of this job offer immediately contact: ____.

If you receive this letter after the start time for the job stated above, then this letter constitutes a new offer of the same modified job at the same start time on the next calendar day after your receipt of this letter, if the employer is open for business on that day, or, if not, then on the next calendar day that the employer is open for business. Regardless of when you receive this letter, please call the employer immediately at the following number to confirm your response to this job offer: .
Your workers' compensation benefits may be adversely affected if you choose not to accept this job offer.

you have the right to refuse an offer of employment without termination of temporary total disability if any of the following conditions apply:

- The offer is at a site more than miles from where the worker was injured, unless the work site is less than miles from the worker's residence, or the intent of the employer and worker at the time of hire or as established by the employment pattern prior to the injury was that the job involved multiple or mobile work sites and the worker could be assigned to any such site. Examples of such sites include, but are not limited to logging, trucking, construction workers, and temporary employees;
- The offer is not with the employer at injury;
- The offer is not at a work site of the employer at injury;
- The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or
- The offer is not consistent with an existing shift change provision of an applicable union contract.

If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reason(s) for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's action(s) to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282.

Sincerely,

I have read and understand this job offer. I accept this job as offered. Yes No

____
Employee Signature Date

Email Template for Safety Manager/HR Office's Inquiry for Intra-Agency Transitional Duties

{Agency} is currently unable to place an injured worker in an appropriate temporary transition work (modified) position. We are seeking help in offering up to {number of days} of temporary transitional work placement for this injured worker. The injured worker (IW) is located in {geographical location, city} and is represented by {union, if applicable}. Current regulations limit the employee's relocation to 50 miles or less. (Agencies must verify any additional or conflicting limitations that may be highlighted in applicable collective bargaining agreements with the agency-at-injury).

Please note that we are not asking to occupy a vacant position; rather, we are looking for a body of work that the employee can perform within their limitations. This body of work could be filing, greeting, phone work, etc.

The IW doctor's limitations are:

{List limitations}.

The IW possesses the skills below:

{What type of experience, skills, knowledge, and abilities does the employee have? What licenses, certifications, computer skills, Oregon Driver License, Commercial Driver License, education? – Goal is to maximize any placement possibilities, within relevant restrictions}.

Under DAS policy 50.020.05 it is understood that the agency-at-injury remains responsible for the IW pay, benefits, and managing of the WC claim. The receiving agency is responsible for supervision of work assignments and reporting of hours worked and missed. If you believe you are able to offer appropriate temporary transitional work for this injured employee please contact {name} at XXX-XXX-XXXXX at your earliest possibility.

ERTW Toolkit Forms

400 High St. SE
Salem, OR 97312

For SAIF Customer Use
Area ______ ______ ______
Dept. ______
Shift ______ **CC** ______

CLAIM NO. ______
SUBJECT DATE ______
CLASS ______
DEFAULT DATE ______
EMPLOYER'S ACCOUNT NO. ______

Email: saif801@saif.com
Toll-free phone: 1.800.285.8525
Toll-free FAX: 1.800.475.7785

Report of Job Injury or Illness

Workers' compensation claim

Worker

To make a claim for a work-related injury or illness, fill out the worker portion of this form and give to your employer. **If you do not intend to file a workers' compensation claim with SAIF, do not sign the signature line.** Your employer will give you a copy.

				DEPT USE:
1. Date of injury or illness:	2. Date you left work:	3. Time you began work on day of injury: ☐ a.m. ☐ p.m.	4. Regularly scheduled days off:	Emp
5. Time of injury or illness: ☐ a.m. ☐ p.m.	6. Time you left work: ☐ a.m. ☐ p.m.	7. Shift on day of injury: (from) ☐ a.m. ☐ p.m. (to) ☐ a.m. ☐ p.m.	☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ S	Ins
8. What is your illness or injury? What part of the body? Which side? (Example: sprained right foot) ☐ Left ☐ Right			9. Check here if you have more than one job: ☐	Occ
10. What caused it? What were you doing? Include vehicle, machinery, or tool used. (Example: Fell 10 feet when climbing an extension ladder carrying a 40-pound box of roofing materials)				Nat Part Ev Src 2src

Information ABOVE this line: date of death, if death occurred; and Oregon OSHA case log number must be released to an authorized worker representative upon request.

11. Your legal name:	12. Worker's language preference other than English: ☐ Spanish ☐ Other (please specify):	13. Birthdate:	14. Gender: ☐ M ☐ F
15. Your mailing address, city, state and zip:			16. Home phone:
17. Social Security no. (see back*):	18. Occupation:		19. Work phone:
20. Names of witnesses:			
21. Name and phone number of health insurance company:		22. Name and address of health care provider who treated you for the injury or illness you are now reporting:	
23. Have you previously injured this body part? ☐ Yes ☐ No			
24. Were you hospitalized overnight as an inpatient? ☐ Yes ☐ No			
25. Were you treated in the emergency room? ☐ Yes ☐ No			

26. By my signature, I am making a claim for worker's compensation benefits. The above information is true to the best of my knowledge and belief. I authorize health care providers and other custodians of claim records to release relevant medical records to the workers' compensation insurer, self-insured employer, claim administrator, and the Oregon Department of Consumer and Business Services. **Notice:** Relevant medical records include records of prior treatment for the same conditions or of injuries to the same area of the body. A HIPAA authorization is not required (45 CFR 164.512(I)). Release of HIV/AIDS records, certain drug and alcohol treatment records, and other records protected by state and federal law requires separate authorization. **I understand I have a right to see a health care provider of my choice subject to certain restrictions under ORS 656.260 and ORS 656.325**.

27. Worker signature:	28. Completed by (please print):	29. Date:

Employer

Complete the rest of this form and give a copy of the form to the worker. Notify SAIF within five days of knowledge of the claim. Even if the worker does not wish to file a claim, maintain a copy of this form.

30. Employer legal business name:		31. Phone:	32. FEIN:
33. If worker leasing company, list client business name:			34. Client FEIN:
35. Address of principal place of business (not P.O. Box):			36. Insurance policy no.:
37. Street address from which worker is/was supervised:		ZIP:	38. Nature of business in which worker is/was supervised:
39. Address where event occurred:			
40. Was injury caused by failure of a machine or product, or by a person other than the injured worker? ☐ Yes ☐ No			41. Class code:
42. Were other workers injured? ☐ Yes ☐ No	43. Did injury occur during course and scope of job? ☐ Unknown ☐ Yes ☐ No		44. OSHA 300 log case no:
45. Date employer knew of claim:	46. Worker's weekly wage: $	47. Date worker hired:	48. If fatal, date of death
49. Return-to-work status: Not returned ☐	☐ Regular Date:	☐ Modified Date:	50. If returned to modified work, is it at regular hours and wages? ☐ Yes ☐ No

By my signature, I acknowledge I am responsible for notifying my workers' compensation insurance company within five days of knowledge of the claim. **I understand I may not restrict the worker's choice of or access to a health care provider. If I do, it could result in civil penalties under ORS 656.260.**

51. Employer signature:	52. Name and title (please print):	53. Date:

801

X801 1/17

OSHA requirements: Employers must report work-related fatalities and catastrophes to Oregon OSHA either in person or by telephone within eight hours. In addition, employers must report any in-patient hospitalization, loss of an eye, and any amputation or avulsion that results in bone or cartilage loss to Oregon OSHA within 24 hours. See OAR 437-001-0704. Call 800.922.2689 (toll-free), 503.378.3272, or Oregon Emergency Response, 800.452.0311 (toll-free), on nights and weekends.

A guide for workers recently hurt on the job

The following information is provided by SAIF at the request of the Workers' Compensation Division

400 High St. SE, Salem, OR 97312

How do I file a claim?

- Notify your employer and a health care provider of your choice about your job-related injury or illness as soon as possible. Your employer cannot choose your health care provider for you.
- Ask your employer the name of its workers' compensation insurer.
- Complete **Form 801, "Report of Job Injury or Illness,"** available from your employer and **Form 827, "Worker's and Physician's Report for Workers' Compensation Claims,"** available from your health care provider.

How do I get medical treatment?

- You may receive medical treatment from the health care provider **of your choice**, including:
  - Authorized nurse practitioners
  - Chiropractors
  - Medical doctors
  - Naturopaths
  - Oral surgeons
  - Osteopathic doctors
  - Physician assistants
  - Podiatrists
  - Other health care providers
- The insurance company may enroll you in a managed care organization at any time. If it does, you will receive more information about your medical treatment options.

Are there limitations to my medical treatment?

- **Health care providers may be limited in how long they may treat you and whether they may authorize payments for time off work.** Check with your health care provider about any limitations that may apply.
- **If your claim is denied, you may have to pay for your medical treatment.**

If I can't work, will I receive payments for lost wages?

- You may be unable to work due to your job-related injury or illness. In order for you to receive payments for time off work, your health care provider must send written authorization to the insurer.
- Generally, you will not be paid for the first three calendar days for time off work.
- You may be paid for lost wages for the first three calendar days if you are off work for 14 consecutive days or hospitalized overnight.
- If your claim is denied within the first 14 days, you will not be paid for any lost wages.
- Keep your employer informed about what is going on and cooperate with efforts to return you to a modified- or light-duty job.

What if I have questions about my claim?

- SAIF or your employer should be able to answer your questions. Call SAIF at 800.285.8525.
- If you have questions, concerns, or complaints, you may also call any of the numbers below:

  Ombudsman for Injured Workers:

  An advocate for injured workers

  Toll-free: 800.927.1271

  Email: oiw.questions@oregon.gov

  Workers' Compensation Compliance Section

  Toll-free: 800.452.0288

  Email: workcomp.questions@oregon.gov

* **Do I have to provide my Social Security number on Forms 801 and 827? What will it be used for?**
You do not need to have an SSN to get workers' compensation benefits. If you have an SSN, and don't provide it, the Workers' Compensation Division (WCD) of the Department of Consumer and Business Services will get it from your employer, the workers' compensation insurer, or other sources. WCD may use your SSN for: quality assessment, correct identification and processing of claims, compliance, research, injured worker program administration, matching data with other state agencies to measure WCD program effectiveness, injury prevention activities, and to provide to federal agencies in the Medicare program for their use as required by federal law. The following laws authorize WCD to get your SSN: the Privacy Act of 1974, 5 USC § 552a, Section (7)(a)(2)(B); Oregon Revised Statutes chapter 656; and Oregon Administrative Rules chapter 436 (Workers' Compensation Board Administrative Order No. 4-1967).

440-3283 (01/17/DCBS/WCD/WEB) for distribution with X801 SAIF 1/17

Return form to:

RETURN-TO-WORK STATUS

Worker's name: ______________________ Claim number (if known): ______________

Next scheduled appointment date: ____________

Is the worker expected to materially improve from medical treatment or the passage of time? ☐ **Yes** ☐ **No**

WORK STATUS *(Select one option)*

☐ **OPTION 1 – Released to Regular Work** Status from (date): ________

Released to the ***hours routinely worked and tasks routinely performed in the job held at the time of injury.***

☐ **OPTION 2 – Not Released to Work** Status from (date): ________ to: ________

The worker is ***not capable of performing any work activities***.

☐ **OPTION 3 – Released to Modified Work** Status from (date): ________ to: ________

Released to work, ***subject to the following work restrictions (note only those that are applicable):***

Total work hours: ____hours/day

Lift/carry/push/pull restrictions

	One-time	*≤1/3 of workday*	*1/3-2/3 of workday*	*≥2/3 of workday*	*Duration*	
Lift:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Carry:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Push:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time
Pull:	____pounds	____pounds	____pounds	____pounds	____hrs./day	____hrs./one time

Activity restrictions

Stand:	____hrs./day	____hrs./one time	***Twist:***	____hrs./day	____hrs./one time	***Crawl:***	____hrs./day	____hrs./one time
Walk:	____hrs./day	____hrs./one time	***Climb:***	____hrs./day	____hrs./one time	***Crouch:***	____hrs./day	____hrs./one time
Sit:	____hrs./day	____hrs./one time	***Bend:***	____hrs./day	____hrs./one time	***Balance:***	____hrs./day	____hrs./one time
Drive:	____hrs./day	____hrs./one time	***Above-shoulder-reach:***	____hrs./day	____hrs./one time	***Below-shoulder-reach:***	____hrs./day	____hrs./one time
Kneel:	____hrs./day	____hrs./one time						

Hand use restrictions

Fine actions:	____hrs./day L hand	____hrs./day R hand
Keyboarding:	____hrs./day L hand	____hrs./day R hand
Grasp:	____hrs./day L hand	____hrs./day R hand

Foot use restrictions

Raise:	____hrs./day L foot	____hrs./day R foot
Push:	____hrs./day L foot	____hrs./day R foot

Notes / other restrictions: ______________________________

____

Medical provider's signature: ______________________ Date: __________

Print medical provider's name: ______________________ Phone no.: __________

13.09 CBIW NOTIFICATION FORM

* * IMPORTANT EMPLOYEE NOTICE * *

State Law ORS 659A.060-659A.069 (CBIW) requires the State as an employer to continue to pay the employer's contribution toward health and dental benefits when coverage under a State plan would otherwise end due to a workers' compensation injury or illness. Failure to continue health and dental benefits for injured or ill workers as provided under ORS 659A.060-659A.069 (CBIW) is an unlawful employment practice. This notice informs you of your rights and obligations under the provisions of this law.

If eligible for continuation of coverage under this law, you will receive the coverage that you had immediately before your on-the-job injury or illness. The law requires that the agency maintain your coverage up to twelve months from the date of knowledge of the injury or illness. However, the law also provides that the agency can end your coverage early for any of the following reasons:

a) Your attending physician or nurse practitioner has decided that you are medically stationary and has entered a determination order or notice of closure;
b) You return to work for any agency of the State after a period of continued coverage under this law, and satisfy any probationary or minimum work requirement to be eligible for group health benefits;
c) You take full or part-time employment with a private or public employer other than the State of Oregon that is comparable in terms of the number of hours per week you were employed with the State, or you retire;
d) Twelve months have elapsed since the date the State received notice that you filed a workers' compensation claim;
e) SAIF denies your claim and you fail to appeal within 60 days or, if you appealed, the Workers' Compensation Board, a worker's compensation hearing referee or a court decides that your claim is not compensable.
f) You do not pay the required premium, or portion thereof, in a timely manner.
g) You elect to discontinue this coverage and notify your personnel, payroll, or campus benefits office of this election in writing.
h) Your attending physician or nurse practitioner has released you to modified/transitional or regular work, you have been offered the work and you refuse to work; or,
i) Employment with the State ends for reasons unrelated to the workers' compensation claim.

If the employer contribution does not cover the full cost of your health and dental premiums, you will be required to pay a portion of the premium to continue coverage. If you fail to make timely payment of any premium contribution owing, you will be notified of the 30-day grace period allowed before cancellation of your coverage. Upon expiration of your coverage under State law, you may be eligible to continue coverage on a self-pay basis under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). In some cases, you may be eligible for some extension of coverage under the Affordable Care Act (ACA).

If SAIF denies your workers' compensation claim, or if you appeal and do not prevail, the State may recover the amount of premiums paid under this law, plus interest. The State may recover the payments through a payroll deduction not to exceed 10% of your gross pay.

If you choose not to receive continued coverage under ORS 659A.063, you may be eligible under the federal COBRA regulations to continue your medical and dental coverage on a self-pay basis for up to 18 months. Premiums for coverage continued under the COBRA provisions are set at 102% of the active group rate for the first 18 months. If Social Security determines disability at the time of your qualifying event or within the first 60 days of your COBRA coverage, you may be entitled to an extension of 11 months, for a total of up to 29 months. If eligible for the extended coverage due to a disability, premiums for months 19 through 29 will be set at 150% of the active group rate. If you would like more information on COBRA or ACA, contact your personnel, payroll or campus benefits office.

Important Employee Notice

State law does not require continuation of any life or disability programs, opt-out bonus, or benefit dollars taken as cash. If you would like more information on how to continue life and disability coverage, please contact your personnel, payroll or campus benefits office. You must self-pay the Long-term Disability (LTD) premiums throughout the elimination period to be eligible for benefits. To continue other benefit plans, such as credit union or automobile insurance, you must contact the company(s) to arrange for continuation of your monthly payments.

* * * * * * * * * * * * * * * *

REINSTATEMENT OF COVERAGE WHEN YOU RETURN TO BENEFIT ELIGIBLE STATUS

All benefits in effect before qualifying for coverage under ORS 659A.060-659A.069 (CBIW) will be automatically reinstated. We request that you complete the necessary Update Forms during the first 60 days of your return to assure that coverage is reinstated promptly. Changes in elections are limited to open enrollment periods or within 60 days following a qualified family status change. See your PEBB Eligibility Handbook for more information on qualified family status change.

Employees who return to benefit eligible status following a leave under ORS 659A.063 (CBIW) are not required to work at least half time to be eligible for benefits the following month if all provisions of ORS 659A.060-659A.069 (CBIW) are met. Half time is defined as 20 hours per week and no less than 80 hours per month; or as defined by collective bargaining.

If coverage under the short or long term disability plans lapse for 90 days or more, you may be subject to new pre-existing condition limitations or waiting periods. For more information, see your PEBB Eligibility Handbook.

* * * * * * * * * * * * * * * *

I ___________________________, have read and received a copy of this form notifying me of my rights while on a workers' compensation claim as an employee of the State of Oregon.

_________________________________ ________________

Employee Signature Date

Worker’s Compensation Elected Leave Form

If you are on authorized SAIF time loss, this form shall be filled out to determine how you choose to cover your absence related to your time loss from _______. If your sick leave is exhausted, you can elect to use other accrued leave, if it is available. If no other accrued leave is available, you will then be placed on approved leave without pay from [agency] while SAIF continues to pay your time loss.

Prorated charges will be made against your accrued sick leave as indicated by your choice (DAS CHRO Sick Leave with Pay Policy, 60.000.01 or applicable bargaining contract language). _______ is required by state law to pay the employer’s contribution toward your core benefits if you lose coverage as a result of an on-the-job injury (Continuation of Benefits for Injured Workers (CBIW) ORS 659A.060-069). Medical and dental coverage may be continued up to twelve (12) months from date of filed claim. You are responsible for the employee portion of your core insurance and If you pay an additional amount for optional insurance out of your monthly check above ________ contribution, you will be required to continue to pay your contribution to maintain the same level of coverage (even if you have exhausted your leave balances). Contact your Payroll department if you have any questions about ensuring your benefits continue.

In addition to your claim, you may be eligible for the Family and Medical Leave Act (FMLA). This coverage may provide up to 12 weeks of job protected leave and medical benefits.

If the time loss claim is denied, you may have to return additional benefit overpayments (in alignment with DAS CFO Collection of Overpayment Policy, 45.50.00 or applicable union bargaining agreements).

Choice (Check One):

☐ ***Option #1 –*** *Use accrued sick leave during the period in which Workers’ Compensation is being received. (This will be equal to the difference between the Workers’ Compensation for lost time and your regular salary rate. SAIF will pay time loss equal to 66 2/3% of your gross salary which is non-taxable. _______ would pay a prorated amount of your gross pay to make up the difference, which is taxable.)*

- ☐ ***–*** *In the event that my sick leave balance is exhausted, I choose to utilize my other leave balances (Vacation, Personal Business, etc.) to cover the different between the time loss payments and my regular salary rate during my absence from _______ while on authorized SAIF time loss.*
- ☐ ***–*** *In the event that my sick leave balance is exhausted, I choose to default to option #2.*

☐ ***Option #2 –*** *Do not use any accumulated leave time during the period in which Workers’ Compensation is being received. Place me on approved leave without pay status. I understand that if I choose this option, SAIF Corporation will pay 66 2/3% of my gross salary (if the claim has been accepted), which is non-taxable.*

I have read the above material and made a choice on how to cover my absence from _______. I understand that if I do not complete this form, my supervisor will place me on leave without pay. I also understand that I am responsible for letting SAIF, my supervisor, payroll, and the safety manager know when time loss has ended and modified or regular work has begun in order to avoid any overpayments.

______________________	__________	______________________	__________
Employee’s Signature	*Date*	*Supervisor’s Signature*	*Date*

______________________	__________
State Employee ID Number	*Date of Injury*

Copy to: Supervisor, Safety Manager, and Payroll

REGULAR JOB DESCRIPTION

Job Title at Injury: ______________________ Worker Name: ______________________

Employer Name: ______________________ Claim Number: ______________________

Date of Injury: ______________________

Job Duties (Be specific as possible breaking the job down into specific tasks performed and include the **% of time and \ frequency**.) Duties for all job tasks performed throughout the year should be included.

Tools & Equipment Used:

____

____

Hours per Day/Week ______________________

Seasonal Work? ☐ **No** ☐ **Yes** **Duration:** ______________________

ENDURANCE

	Never	Seldom 1-5%	Occas. 6-33%	Freq. 34-66%	Continuous 67-100%	Total Hours At one time	Total Hours in a work day
Sitting							
Standing							
Walking							
Change Positions?							

PHYSICAL REQUIREMENTS: (Enter actual maximum weight in pounds in the box)

Lifting:

	Never	Seldom 1-5%	Occas. 6-33%	Freq. 34-66%	Continuous 67-100%
10-14 lbs					
15-20 lbs					
21-50 lbs					
51-75 lbs					
76 –100 lbs					
>100 lbs					

Maximum # lifted by worker without assistance ______________________

If required, lifts over __________ **# are performed with** ☐ **two or more people** ☐ **lift devices**

Carrying:

	Never	Seldom 1-5%	Occas. 6-33%	Freq. 34-66%	Continuous 67-100%
10-14 lbs					
15-20 lbs					
21-50 lbs					
51-75 lbs					
76 –100 lbs					
>100 lbs					

Maximum # carried by worker without assistance ______________________

If required, carrying over ______ **# is performed with two or more people or with lift devices.**

Pushing/Pulling force to be exerted:

	Never	Seldom 1-5%	Occas. 6-33%	Freq. 34-66%	Continuous 67-100%
10-14 lbs					
15-20 lbs					
21-50 lbs					
51-75 lbs					
76 –100 lbs					
>100 lbs					

Maximum weight of object pushed/pulled by worker ______________________

Distance: _____________ **Type of Surface (ie level, carpet, incline)** _____________

	Never	Seldom 1-5%	Occas. 6-33%	Freq. 34-66%	Continuous 67-100%
Bend/Stoop					
Twist					
Crouch/squat					
Kneel					
Crawl					
Walk-Level surface					
Walk-Uneven surface					
Climb Steps					
Climb Ladder					
Work at heights					
Reach at or above Shoulder					
Reach below shoulder					
Use of Arms					
Use of Wrist					
Use of Hands					
Grasping/squeezing					
Operate foot controls					

Environment: ☐ Inside ______ % of time ☐ Outside ______ % of time

Temperature Extremes ☐ Yes ☐ No Vibration ☐ Yes ☐ No

Works on or around moving machinery or mechanical parts ☐ Yes ☐ No

Personal Protective Equipment:

☐ Boots ☐ Hardhat ☐ Gloves ☐ Glasses ☐ Hearing ☐ Other _____________

SIGNATURES

The information provided in this description, including strength and physical requirements, is based on observation of the job and is accurate to the best of my knowledge.

Employee Signature ____________________________________ Date ____________________

Employer Representative(s):

Print Name	Title	Signature	Date

Prepared by: ____________________________________ Date: ____________________

For physician to complete:

Is this job appropriate? ☐ **Yes** ☐ **No** **Date of Release:** ____________________

If not released to regular work at this time, please provide an "ANTICIPATED" DATE: ____________

______________________________ ______________________________

Physician's Signature Date

TASK INVENTORY FOR MODIFIED/TRANSITIONAL DUTY

TASK_______________________________________ WORK AREA ____________________

SUPERVISOR ______________________________ PHONE ________________________

PHYSICAL REQUIREMENTS:

TASK_______________________________________ WORK AREA ____________________

SUPERVISOR ______________________________ PHONE ________________________

PHYSICAL REQUIREMENTS:

TASK_______________________________________ WORK AREA ____________________

SUPERVISOR ______________________________ PHONE ________________________

PHYSICAL REQUIREMENTS:

TASK_______________________________________ WORK AREA ____________________

SUPERVISOR ______________________________ PHONE ________________________

PHYSICAL REQUIREMENTS:

WORKERS' COMPENSATION INJURED WORKER
AGENCY TRANSITIONAL WORK AGREEMENT (used within the same agency)

1. EMPLOYEE NAME	2. EMPLOYEE ID NUMBER	3. ASSIGNED DISTRICT/PROGRAM

4. INJURY DATE	5. ASSIGNMENT BEGINS	6. ASSIGNMENT EXPECTED TO END	7. REGULAR AND (IF APPLICABLE) ASSIGNED SUPERVISOR FOR TRANSITIONAL WORK

8. SHIFT HOURS / DAYS	9. PHYSICIAN NAME AND TITLE

10. **30-**DAY REVIEW	11. **60-**DAY REVIEW	12. **90-**DAY REVIEW	13. **120-**DAY REVIEW

14. LIMITATIONS / RESTRICTIONS (PER DOCTOR RELEASE ON FILE)

15. TRANSITIONAL ASSIGNMENT DETAILS / DESCRIPTION

Employee will follow limitations specified by doctor (noted above) while performing duties. Employee will discuss/arrange with regular and transitional supervisor, dates and times for doctor, chiropractor, physical therapy appointments as prescribed by MD in a written doctor's note.

Job Duties: Employee will be required to satisfactorily complete job tasks as assigned, with the above limitations observed and duties performed accordingly. Transitional work will end whichever of the following occurs first:

1. Transitional work is no longer available.*
2. Your doctor releases you to regular work.
3. Your doctor indicates that you are medically stationary and have permanent restrictions as a result of the injury that will prevent you from returning to your regular job.
4. Your claim for worker's compensation benefits is denied.
5. One hundred twenty (120) consecutive calendar days have elapsed from the beginning date of the transitional duty. (Refer to the DAS Policy DAS-50.020.05, Early Return to Work of Injured Workers and ORS 659A.063).

* If supervisor is made aware of, witnesses, or provides witnesses that will state that employee is not working within doctor's restrictions, transitional duties can be terminated immediately.

Due to the above limitations of the employee, unless specifically addressed on the work release, work on holidays or overtime will not be allowed or approved. Wages and benefits will remain the same during transitional duties.

Unless a significant change is noted by the doctor (in writing) this agreement will be in effect for 120 consecutive calendar days and evaluated every 30 days by Supervisor and Workers Compensation Manager for job modification(s) until employee is released to full duty or 120 days has elapsed. Submission of a full release immediately terminates this agreement, and employee is released back to their regular job duties without restrictions. In accordance with DAS Policy-50.020.05, after exhaustion of 120 days, the employee will be sent home until a full release is presented to supervisor. SAIF will be notified and time loss payments may start the following day.

Injured workers are to submit a new doctor's release every two weeks or at least after each medical appointment. All doctor releases are to be submitted to the Supervisor and Safety Manager within 24 hours of receipt. **Worker will use own accrued leave, in accordance with applicable agency leave policies or union contract articles, to cover missed time for all medical appointments (Doctor, PT, and Chiropractic) unless visit is requested by SAIF. All sick days will be covered by employee's sick leave, per agency leave policy or applicable union contract articles. Contact your Claims Adjuster as SAIF may pay time loss if a doctor's note is provided excusing employee for a specific day due to on-the-job injury.**

EMPLOYEE'S SENDING SUPERVISOR PRINT NAME	EMPLOYEE'S SENDING SUPERVISOR SIGNATURE	DATE
EMPLOYEE'S RECEIVING SUPERVISOR PRINT NAME	EMPLOYEE'S RECEIVING SUPERVISOR SIGNATURE	DATE
SAFETY MANAGER/ HUMAN RESOURCES PRINT NAME	SAFETY MANAGER/ HUMAN RESOURCES SIGNATURE	DATE

I have read the above transitional job duties and responsibilities. I understand that these job duties have been assigned in compliance with my physician's orders. I agree to abide by these limitations and to notify my supervisor immediately of any problems or change in my physical condition.

EMPLOYEE PRINT NAME	EMPLOYEE SIGNATURE	DATE

[Sending Agency Logo Here]

Early Return to Work
Intra-Agency Modified Work Assignment
MEMORANDUM OF AGREEMENT

ASSIGNMENT DETAILS			
1. EMPLOYEE NAME		2. EMPLOYEE ID #	3. CURRENT CLASSIFICATION TITLE
4. SENDING AGENCY / AGENCY #		5. RECEIVING AGENCY / AGENCY #	
6. REGULAR SUPERVISOR NAME AND CONTACT INFO.		7. RECEIVING SUPERVISOR NAME AND CONTACT INFO.	
8. ASSIGNMENT BEGIN DATE		9. EXPECTED ASSIGNMENT END DATE (not to exceed 120 days)	
10. SHIFT HOURS / DAYS		11. PHYSICIAN NAME AND TITLE	
12. 30-DAY REVIEW	13. 60-DAY REVIEW	14. 90-DAY REVIEW	15. 120-DAY REVIEW
16. LIMITATIONS / RESTRICTIONS (PER DOCTOR RELEASE ON FILE)			
17. TRANSITIONAL ASSIGNMENT DETAILS / DESCRIPTION			

CONDITIONS OF AGREEMENT INCLUDE THE FOLLOWING:

- Transitional work will be offered in accordance with the CHRO Early Return to Work of Injured Workers policy, 50.020.05.
- The home agency-at-injury remains responsible for the employee’s pay, benefits, and managing of the WC claim.
- The receiving agency is responsible for supervision, work assignments and reporting of hours worked and missed.
- The employee, if represented, remains covered under their bargaining unit.
- This is a transitional work assignment, subject to a review every 30 days or sooner, and can be ended by either agency at any time.
- The sending supervisor will keep the receiving supervisor up-to-date on the employee's most recent work restrictions.
- The receiving supervisor will assign work in alignment with the employee's current work restrictions.
- The employee will perform assigned work in alignment with their current work restrictions.
- The employee's employment status and permanent classification does not change. The employee will be granted any salary adjustments or any increases for which they are eligible.
- The employee will remain eligible for agency promotional opportunities (in sending agency).
- All BOLI reinstatement / reemployment rights remain with the agency-at-injury.
- Failure to accept a bona fide offer of transitional work may impact the employee’s reemployment and reinstatement rights.
- Workers’ compensation coverage is provided by sending Agency.
- Other applicable special conditions: ______________________________

SIGNATURES *(By signing this document you agree to all the terms and conditions of the assignment listed above.)*

EMPLOYEE’S SENDING SUPERVISOR PRINT NAME	EMPLOYEE’S SENDING SUPERVISOR SIGNATURE	DATE
EMPLOYEE’S RECEIVING SUPERVISOR PRINT NAME	EMPLOYEE’S RECEIVING SUPERVISOR SIGNATURE	DATE
SAFETY MANAGER/ HUMAN RESOURCES PRINT NAME	SAFETY MANAGER/ HUMAN RESOURCES SIGNATURE	DATE

In addition to the terms above, the employee will discuss/arrange with regular and transitional supervisor, dates and times for doctor, chiropractor, physical therapy appointments as prescribed by MD in a written doctor's note.

Job Duties: Employee will be required to satisfactorily complete job tasks as assigned, with the above limitations observed and duties performed accordingly. Transitional work will end whichever of the following occurs first:

1. Transitional work is no longer available.*
2. Your doctor releases you to regular work.
3. Your doctor indicates that you are medically stationary and have permanent restrictions as a result of the injury that will prevent you from returning to your regular job.
4. Your claim for worker's compensation benefits is denied.
5. One hundred twenty (120) consecutive calendar days have elapsed from the beginning date of the transitional duty. (Refer to the DAS Policy DAS-50.020.05, Early Return to Work of Injured Workers and ORS 659A.063).

* If supervisor is made aware of, witnesses, or provides witnesses that will state that employee is not working within doctor's restrictions, transitional duties can be terminated immediately.

Due to the above limitations of the employee, unless specifically addressed on the work release, work on holidays or overtime will not be allowed or approved. Wages and benefits will remain the same during modified duty period.
Unless a significant change is noted by the doctor (in writing) this agreement will be in effect for 120 consecutive calendar days and evaluated every 30 days by Supervisor and Workers Compensation Manager for job modification(s) until employee is released to full duty or 120 days has elapsed. Submission of a full release immediately terminates this agreement, and employee is released back to their regular job duties without restrictions. In accordance with DAS Policy-50.020.05, after exhaustion of 120 days, the employee will be sent home until a full release is presented to supervisor. SAIF will be notified and time loss payments may start the following day.
Injured workers are to submit a new doctor's release every two weeks or at least after each medical appointment. All doctor releases are to be submitted to the Supervisor and Safety Manager within 24 hours of receipt. **Worker will use own accrued leave, in accordance with applicable agency leave policies or union contract articles, to cover missed time for all medical appointments (Doctor, PT, and Chiropractic) unless visit is requested by SAIF. All sick days will be covered by employee's sick leave, per agency leave policy or applicable union contract articles. Contact your Claims Adjuster as SAIF may pay time loss if a doctor's note is provided excusing employee for a specific day due to on-the-job injury.**

I have read the above job duties and responsibilities. I understand that my job duties have been assigned in compliance with my physician's orders. I agree to abide by these limitations and to notify my regular and transitional (receiving) supervisor immediately of any problems or change in my physical condition.

EMPLOYEE PRINT NAME	EMPLOYEE SIGNATURE	DATE