

STATE OF MARYLAND

MANAGED RETURN TO WORK PROGRAM  
(MRTW)

POLICY

REQUIREMENTS AND PROCEDURES

DEPARTMENT OF BUDGET & MANAGEMENT

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## DEFINITIONS

As specifically referenced and within the context of this policy, the following terms have the meanings indicated:

**Accident:** A sudden and unexpected occurrence at work, whether or not it results in a physical injury.

**Accident Leave:** Leave provided to an employee who has sustained a work-related disabling personal injury (as certified by a licensed physician) that is compensable under the Maryland Workers' Compensation Act. Payment of accident leave equals two-thirds of the employee's regular pay and is excluded from Federal adjusted gross income and therefore not subject to either Federal or State income tax.

**Americans With Disabilities Act (ADA):** a Federal law that protects individuals from discrimination on the basis of disability and requires reasonable accommodation in the workplace.

**Compensability:** refers to eligibility for benefits under the Workers' Compensation Act. Not all injuries occurring in the course of employment are compensable. IWIF makes an initial determination on compensability of a workplace injury; the Workers' Compensation Commission makes the final determination.

**DBM:** Department of Budget and Management

**Family and Medical Leave Act (FMLA):** a Federal law that entitles eligible employees to an absence of up to 12 workweeks of leave in any 12-month period for a serious health condition that makes an employee unable to perform the functions of the employee's job.

**Full Normal Employment:** The usual job duties assigned to an employee before the employee sustained an on-the-job injury.

**Injured Workers' Insurance Fund (IWIF):** The State's third party administrator for workers' compensation responsible for making initial determinations on compensability of workplace injuries.

**Injury:** A personal injury or occupational illness that occurs in the course of employment.

**Lost Time Case:** Any case where the injured worker is absent for more than 3 consecutive days, based upon the waiting period for Maryland's Workers' Compensation.

**Managed Return to Work (MRTW) Program:** A comprehensive, proactive program that provides suitable temporary transitional duty as a bridge back to full normal employment as quickly as medically possible.

**Maximum Medical Improvement (MMI):** The point at which an employee has recovered and no further progress is anticipated, as certified by a licensed physician.

**Meaningful Work:** Productive work that is useful to the employer's operations. Meaningful work is not necessarily at the same performance level of a non-injured employee, but it provides a means to return the injured employee to full productivity. It increases the likelihood of compliance with the MRTW Program by employees at all levels.

**Medical Restrictions:** Physical limitations on the type and duration of physical effort the injured employee can tolerate as certified by a licensed physician. These may include consideration of environmental conditions and treatment needs.

**Physician's Medical Assessment of Employee:** The form completed by the treating physician that provides the injured employee's prognosis, recommended treatment plan, allowed activities and projected length of time of restrictions. It notifies the physician that the State offers transitional duty assignments, provides employer and Workers' Comp information and includes an employee medical release as it relates to the work-related injury.

**State Medical Director (SMD):** The entity designated by the Secretary of DBM that exercises all authority vested in the Secretary with respect to medical examinations and investigations relating to State employment.

**Suitable Work:** Work that is productive and meaningful, in compliance with the injured employee's medical restrictions and allows the employee to safely and progressively assume full, pre-injury duties.

**Task Analysis:** A process that identifies the ergonomic requirements of specific jobs. It focuses on individual tasks that comprise a job function and assesses the physical demands of such tasks.

**Transitional Duty:** A short-term assignment that complies with temporary medical restrictions (as certified by a licensed physician) and includes temporary alternate functions which are less physically demanding than the employee's normal job.

**Work-Related Injury:** An injury or occupational illness as defined in the Workers' Compensation Act.

**Workers' Compensation Coordinator:** The individual in an agency responsible for working with agency officials, IWIF, treating physicians and injured employees to administer the MRTW Program. The Coordinator provides guidance to employees and supervisors regarding MRTW policy requirements and procedures, assists with documentation for transitional duty assignments and assesses MRTW Program training needs.

# **MRTW PROGRAM**

## **POLICY STATEMENT**

The State of Maryland is committed to providing a safe and healthy work environment for its employees. State agencies will attempt to provide suitable, short-term transitional duty assignments as a bridge back to full normal work when an employee sustains a disabling personal injury that is compensable under the Workers' Compensation Act and results in temporary inability to perform normal work, as certified by a physician. If an employee's work limitations resulting from a work related injury are permanent, the employee is not eligible for participation in the MRTW Program.

Suitable work is productive and useful to the agency's operations and complies with the employee's medical restrictions to allow a safe return to work as quickly as possible. Suitable transitional work allows the employee to progressively assume full, pre-injury duties. The MRTW Program does not require State agencies to create unnecessary work when suitable transitional work is not available. Employees who decline suitable transitional duty assignments will be placed on leave without pay until they are able to resume full normal duty.

Transitional duty assignments are temporary and initially may be established for up to 45 calendar days. Agency management may extend the temporary transitional duty period up to an additional 30 calendar days based upon prognosis for further recovery and medical documentation from a licensed physician. Transitional duty assignments may not exceed a maximum of 75 calendar days per injury and may be either full-time or part-time.

Agency management and employees must comply with the "MRTW Policy, Requirements and Procedures" published by DBM.

## **I. WHAT IS THE MRTW PROGRAM?**

The MRTW Program is an employee benefit for individuals with work-related injuries who are temporarily unable to fully perform normal work. The Program provides these employees with meaningful and productive temporary transitional duty assignments. Transitional duty provides a bridge to resuming all of the usual job duties the employee performed prior to sustaining an on-the-job injury. The goal is to return employees to full normal employment as quickly as medically possible.

Important components of the MRTW Program include:

- Prompt reporting of injuries;
- Task analyses of job classifications prepared in advance of injury;
- Prompt and periodic medical assessments;
- Pro-active management of lost-time cases; and
- Active management of transitional duty assignments.

## **II. WHY PROVIDE THE MRTW PROGRAM?**

The MRTW Program provides many direct and indirect benefits for both the employer and employee, such as:

- Maintaining job skills;
- Facilitating recovery by keeping injured workers conditioned to the normal work schedule;
- Reducing impact of injury on the employee's family;
- Enhancing employer/employee relationships;
- Decreasing costs of substitute employees; and
- Reducing the direct and indirect costs of workers' compensation.

### **III. WHEN ARE EMPLOYEES ELIGIBLE FOR TRANSITIONAL DUTY ASSIGNMENTS UNDER THE MRTW PROGRAM?**

For an injured employee to be considered for a transitional duty assignment, the following conditions must apply:

- The employee is unable to perform some or all of the duties and responsibilities of his/her normal job assignment due to a work-related injury that is determined to be compensable under the Workers' Compensation Act;
- The employee's inability to perform some or all of the normal job duties and responsibilities is **temporary**;
- The employee has been released by a physician to perform some meaningful duties and responsibilities without jeopardizing the safety of the employee, coworkers or wards of the State; and
- The employee has not reached maximum medical improvement in the opinion of the treating physician.

### **IV. IMPLEMENTING THE MRTW PROGRAM**

Agencies must comply with the MRTW Policy, Requirements and Procedures published by DBM.

A team approach is vital to the success of the MRTW Program and requires participation and cooperation from supervisors, Workers' Compensation Coordinators, Human Resources personnel, risk managers, health care providers, employees and IWIF.

For questions concerning the MRTW Program, please contact Kim Scott, Department of Budget and Management (DBM), Office of Personnel Services and Benefits (OPSB), at 410-767-4721 or kimberly.scott@maryland.gov.



## **V. INTER-RELATIONSHIPS AMONG THE MRTW PROGRAM AND APPLICABLE FEDERAL AND STATE LAWS**

The following laws may apply when administering the MRTW Program:

- State Workers' Compensation Act – provides for medical and income replacement benefits for employees with compensable work-related injuries;
- ADA – provides protection from discrimination because of disability;
- Family and Medical Leave Act (FMLA) – provides job security for employees with serious health conditions; and
- State Accident Leave Law – provides guidance on the prompt, efficient and uniform management of on-the-job injuries and illnesses.

While these laws serve different purposes, they may apply when an employee with a compensable work-related injury meets the criteria for protections under any of these laws. Agencies must comply with the requirements of these laws when administering the MRTW Program. Agencies should consult their human resources personnel and legal counsel to ensure compliance with all applicable State and Federal laws.

## **VI. ESTABLISHING THE FRAMEWORK FOR MRTW BEFORE AN INJURY OR ILLNESS OCCURS**

### **DEFINE EXPECTATIONS**

The employer will inform all employees about expectations and responsibilities outlined in the MRTW Policy, Requirements and Procedures and include the MRTW Policy in new employee orientation materials.

## **DESIGNATE A WORKERS' COMPENSATION COORDINATOR**

The employer will designate an employee to function as the Workers' Compensation Coordinator with responsibility for:

- Working with supervisors, managers, physicians, IWIF and injured employees to administer the MRTW Program;
- Providing guidance to employees and supervisors regarding requirements and procedures of the MRTW Program;
- Assessing and coordinating training; and
- Completing MRTW Program documentation.

## **CLARIFY THE ROLE OF AGENCY HUMAN RESOURCES PERSONNEL IN ADMINISTRATION OF THE MRTW PROGRAM**

The staff of the agency's Human Resources office may be called upon to provide guidance and coordinate workers' compensation benefits, payroll and leave issues, such as sick leave, leave bank, accident leave and FMLA and assist supervisors and Workers' Compensation Coordinators with identifying transitional duty assignments.

## **COMPLETE TASK ANALYSES**

The task analysis documents the ergonomic assessment of specific job tasks by separating and identifying physical tasks performed by specific job classifications and assessing the ergonomic demands of each task (such as endurance, postures, work environment, weight and exertion requirements and safety equipment needed). It applies to specific job classifications, not individual positions.

Based upon a review of injury data and other work environment factors, the employer identifies jobs and tasks that are most likely to experience injury. Task analyses are then completed for those jobs through interviews and observations. **The Task Analysis Form and Guidance for Completing the Analysis** are contained in **Appendix A**.

Task analyses are completed **before** an injury occurs. **After** an injury occurs, the employer reviews the medical assessment of the employee and the physical demands documented in the task analyses to identify an appropriate transitional duty assignment that complies with the employee's temporary medical restrictions.

It is important to periodically review and update task analyses to incorporate changes that may have occurred in tasks and to include tasks that were not previously analyzed but are currently experiencing injuries.

## **VII. WHAT TO DO AFTER AN INJURY OR ILLNESS OCCURS**

### **OBTAIN MEDICAL ASSESSMENT**

#### **The Employer Shall:**

- Obtain emergency medical services, if necessary. Refer the employee for initial medical assessment by the State Medical Director. The employee may elect to seek medical treatment for the work-related injury from any health care provider. This does not preclude the employer from referring the employee to the State Medical Director or any other physician for evaluation purposes.
- Accompany the employee to the initial medical assessment, if practical.
- Provide the employee with the **Physician's Medical Assessment of Employee form (Appendix C)** for completion by the treating physician.
- Follow-up with the employee and/or treating physician if the **Physician's Medical Assessment** is not received within 24 hours of the medical assessment.
- As needed, arrange for a second medical opinion by the State Medical Director. A second medical opinion may be necessary if the employee's treating physician indicates the employee has significant restrictions that preclude the employee from performing a transitional duty assignment and the employer would like another medical opinion to assist in identifying medically appropriate transitional assignments. The State will accept the second medical opinion in determining the employee's ability to perform appropriate transitional assignments. If the employee is on FMLA leave, arrange for a second medical opinion by a panel physician provided by the State's TPA for workers' compensation.
- Contact the employee every two weeks, as the employee's medical condition dictates, to discuss the employee's progress until such time as the employee is able to perform either full normal duty or transitional duty.

### **The Employee Shall:**

- Inform the treating physician that the State provides transitional work assignments that comply with restrictions on activities during the period of recovery.
- Undergo initial and periodic medical assessments by either the State Medical Director or personal treating physician until able to return to full normal duties.
- Provide the treating physician with the **Physician's Medical Assessment** during each visit and ensure that the form is completed and returned to the employer within 24 hours of each assessment.
- **Immediately** notify the employer of changes in medical condition and/or allowed activities.

### **Physician's Role:**

The treating physician will perform a medical assessment of the injured employee that includes recommended treatment plan, allowed activities, projected duration of restrictions and anticipated date of MMI. The treating physician is **not** responsible for making employment decisions; the **employer** will make determinations about suitable transitional assignments based upon the physician's medical assessment.

## **REPORT ACCIDENTS AND INJURIES**

### **The Employee Shall:**

- Immediately report all work related accidents and injuries to the supervisor verbally or by completing the **Employee's Report of Injury form (Appendix B – Accident Investigation Forms)**.

### **The Employer Shall:**

- Report all accidents and injuries to IWIF within **24 hours** of notice by completing the Employer's First Report of Injury. The employer may report on-line ([www.IWIF.com](http://www.IWIF.com)), by phone (1-888-410-1400) or fax (410-494-2209);
- Place the employee on accident leave pending an initial determination of compensability by IWIF;
- Notify IWIF when the employee is placed on accident leave;
- Keep IWIF apprised of the status of the case; and
- Notify IWF when accident leave is terminated.

## **INVESTIGATE WORKPLACE INJURIES**

### **The Employer Shall:**

- Follow requirements for investigating job-related accidents and injuries. Procedures and forms (**Appendix B**) for accident investigation are available as fillable forms on IWIF's website at [www.IWIF.com](http://www.IWIF.com).
- Obtain a signed, dated statement of the accident from the employee, an investigation report from the supervisor and the names, addresses and statements of any witnesses.
- Send the completed statements and any available medical reports to the IWIF claims adjuster.
- Maintain copies of all investigation forms in the employee's workers' compensation file.

## **ESTABLISH TRANSITIONAL DUTY ASSIGNMENTS**

Transitional Duty Assignments are ***temporary***. Initial transitional duty assignments may last up to **45 calendar days**. With medical documentation, initial assignments may be extended up to a maximum of an additional **30 calendar days**. Under no circumstances may a transitional duty assignment exceed **75 calendar days**.

### **Transitional Duty Assignments may include:**

- Modifications of normal work activities;
- Non-routine job functions;
- Duties of equivalent or lower-level job classifications;
- Part-time or full-time hours, depending on the employee's medical restrictions. If the employee is only able to work part-time hours, the employee may qualify for paid leave for the hours s/he is unable to work;
- Teleworking opportunities, if applicable; and/or
- Employee development activities

**Transitional Duty Assignments may temporarily change:**

- Regular days off and holiday leave;
- Daily work hours and shifts;
- Shift differential;
- Accident leave wages or temporary total disability payments; and/or
- Location of the employee's duty station.

Transitional duty will **not** affect medical benefits or change the employee's base salary. If an employee's work limitations resulting from a work-related injury are permanent, the employee is **not** eligible for a transitional duty assignment.

**IDENTIFY TRANSITIONAL DUTY ASSIGNMENTS FOR AN INJURED EMPLOYEE**

Following receipt of the **Physician's Medical Assessment**, the Employer will determine if suitable transitional work is available by:

- Comparing the **Physician's Medical Assessment** to the **Task Analysis Forms** completed for the employee's normal job classification as well as for other job classifications
- Allowing for the employee's medical restrictions and consulting with the treating physician as needed for clarification of permissible activities.
- Considering the following factors:
  - 1) staffing needs;
  - 2) fiscal/budgetary constraints;
  - 3) safety of employee, coworkers and wards of the State;
  - 4) internal agency policies; and
  - 5) provisions of union Memoranda of Understanding.
- Remaining flexible and creative when determining a suitable transitional assignment for the injured employee.

If suitable transitional work is not available, the employer shall continue the employee on appropriate leave or temporary total benefits until a suitable transitional duty assignment becomes available or the employee's condition improves sufficiently for the employee to resume full normal duties.

## **OFFER TRANSITIONAL DUTY ASSIGNMENTS**

### **The Employer Shall:**

- 1) Prepare a **Transitional Job Offer Letter (Appendix D)** that includes:
  - A brief description of the transitional duty assignment and the physical requirements that comply with the employee's medical assessment;
  - Anticipated duration of the assignment;
  - The employee's transitional work schedule and regular pay rate;
  - The location of the assignment;
  - The name of the supervisor to whom the employee will report; and
  - A section for the employee to indicate acceptance or refusal of the assignment.
- 2) If the employee has been out of work, send the **Transitional Job Offer Letter** to the employee via certified **and** regular mail and ensure that the letter is returned with the employee's signature and indication of whether the offer was accepted or declined. Hold the transitional duty assignment open for **5 workdays** following the date the employee receives the letter.
- 3) If the employee is at work and has not lost time as a result of the injury, the Transitional Job Offer letter can be presented to the employee in person. The employee must sign the letter and indicate whether the transitional job offer is accepted or declined.
- 4) Discuss the details and conditions of the transitional duty assignment with the employee as soon as possible after the employee receives the **Transitional Job Offer Letter**.
- 5) Ensure that the employee understands the consequences of declining an offer of suitable transitional work.
- 6) Send copies of the signed **Job Offer Letter** and **Physician's Medical Assessment** to IWIF.

## **If the Employee Declines An Offer of Suitable Transitional Duty, the Employer Shall:**

- Terminate accident leave and place the employee on leave without pay. Employees on FMLA may decline a transitional duty assignment. In such situations, the employee is entitled to continue on **unpaid** FMLA either until the employee is able to return to work to the same or equivalent job or the 12-week FMLA entitlement is exhausted, whichever occurs first.
- Disallow all other paid leave that requires supervisory approval (i.e., annual, sick and compensatory leave) for periods that the employee is **able** to work. The employee is permitted to use personal leave, to the extent available.
- Request IWIF to suspend payment of wage replacement benefits, as applicable.

## **MANAGE TRANSITIONAL DUTY ASSIGNMENTS**

### **The Employer Shall:**

- Consider the employee's injuries and current medical restrictions to be sure the employee is an appropriate candidate for the Program. If the injuries preclude the employee from reporting to work, the best approach is to wait until the employee has recovered to some extent before offering a transitional assignment. The ideal situation allows the employee to return to full duty immediately after participating in the Program. Employers should consult with the IWIF claims adjuster to discuss the proper time to offer an injured employee a transitional job assignment.
- Provide training as needed for performance of assigned tasks.
- If the assignment is not at the normal duty station, coordinate with the employee and the regular supervisor about available leave, work performance and other matters as needed. The employee's regular supervisor is responsible for completing the employee's performance appraisals.
- Monitor the employee's progress to ensure compliance with medical restrictions.
- Periodically meet with the employee to resolve difficulties with the assignment and document the employee's progress.



### **The Employee Shall:**

- Comply with medical restrictions, both on and off the job, to ensure maximum medical improvement.
- Immediately report any difficulties with performing assigned work or changes in medical condition and allowed activities. The assigned transitional duty may need to be modified.

### **TERMINATE TRANSITIONAL DUTY ASSIGNMENTS**

#### **The Employer shall terminate transitional duty when the Employee:**

- Is released by the treating physician as able to fully resume normal work functions; **or**
- Uses the allowed number of days for transitional work; **or**
- Reaches maximum medical improvement and is **unable** to return to full normal duties.

If the employee is unable to return to full normal activity but is able to perform some duties, the employer should review the appropriateness of permanent changes to the employee's job and ensure compliance with the provisions of the ADA. If work limitations are **permanent**, the employee is not eligible for continued participation in the MRTW Program.

## **REFERENCES**

### **Federal Laws**

Americans with Disabilities Act of 1990, Title 1 - 42 U.S.C. 12101 et seq. (1994)

Family and Medical Leave Act of 1993 - 29 U.S.C. 2601 et seq.

Occupational Safety & Health Act - 29 U.S.C. 651 et seq. (1970)

### **Annotated Code of Maryland**

Accident Leave - State Personnel and Pensions Article, Title 9, Subtitle 7 (§9-701 through 9-705)

Workers' Compensation Act - Labor & Employment Article, Title 9, Subtitle 6 - statutory waiting period (§9-620) and payment of compensation (§9-621)

### **Code of Maryland Regulations (COMAR)**

Accident Leave - COMAR 17.04.11.07

### **State Policies**

Accident Leave Policy prepared by DBM's Office of Personnel Services & Benefits - effective January 2000

Family and Medical Leave Act Guide prepared by DBM's Office of Personnel Services & Benefits - effective November 1999

## APPENDIX A

### TASK ANALYSIS FORM AND GUIDANCE FOR COMPLETING THE ANALYSIS

#### INSTRUCTIONS FOR COMPLETING JOB/TASK ANALYSIS

The task analysis is used to analyze specific job functions/tasks that may be appropriate for transitional duty assignments.

1. Select job classification and/or specific job function/task to be analyzed.
2. Complete the identification portion of the form (job title, work days, work hours). The Job Classification should be the lowest job classification that can do the task.
3. Jointly interview the direct supervisor and an employee who performs the job function/task to be analyzed to determine all tasks and components of those tasks that are performed within the selected Job Title/Task. Complete the Task Summary portion of the form.
4. Schedule a time to observe the employee performing the tasks. The direct supervisor should be available to assist in answering any questions pertaining to the task being performed.
5. While observing the performance of the job tasks, complete the portion of the Job/Task Analysis Form that lists the separate physical demands (e.g. sitting, standing, walking, lifting, etc.). Complete the requested information for each physical activity. Assign a frequency/percent of time rating for each activity using the rating scale provided. For example, if an employee is required to sit for the majority of time to perform a task, enter "continuously" which indicates that the employee sits 67-100% of the time. Identify each activity that requires the physical activities listed. For example, when completing the form for a heavy equipment driver, the Pushing/Pulling Section should include information such as "Weight: Requires ability to pull up to 7 lbs. in upward direction & to push up to 5 lbs. force in downward vertical direction to apply and release parking brake."
6. Identify any Safety Equipment used and any Machines/Tools/Equipment used as part of job or task being analyzed.
7. Attach photos of an employee performing the Task/Job, if possible. Try to include photos of any physical demands listed in the Task Analysis. For example, if you indicated the employee needs to carry files around an office 20% of the time, take a picture of the types of files s/he would be carrying or of someone actually carrying them.

**APPENDIX A (Continued)**

**TASK/JOB ANALYSIS FORM**

**TASK #** \_\_\_\_\_ **TASK/JOB TITLE:** \_\_\_\_\_

**Job Classification:** \_\_\_\_\_ **Prepared By:** \_\_\_\_\_

**Agency:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Work Days:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Work Hours:** \_\_\_\_\_ **Information Received From:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**TASK SUMMARY (Brief description of task or job):**

<b>FOR FREQUENCY/PERCENT OF TIME, USE THE FOLLOWING SCALE</b>			
<b>Continuously (67 - 100%) (5 - 8 hour/8 hour day)</b>	<b>Frequently (34 - 66%) (2.5 - 5 hour/8 hour day)</b>	<b>Occasionally (6 - 33%) (30 min - 2.5 hour/8 hour day)</b>	<b>Rarely (1 - 5%) (0-30 min/8 hour day)</b>

<p><b><u>SITTING</u></b></p> <p>Percent of Time: _____</p> <p>Surface: _____</p>	<p>Hours at One Time: 0 1 2 3 4 5 6 7 8</p> <p>Total Hours in 8-Hour Day: 0 1 2 3 4 5 6 7 8</p>
<p><b><u>STANDING</u></b></p> <p>Percent of Time: _____</p> <p>Surface: _____</p>	<p>Hours at One Time: 0 1 2 3 4 5 6 7 8</p> <p>Total Hours in 8-Hour Day: 0 1 2 3 4 5 6 7 8</p>
<p><b><u>WALKING</u></b></p> <p>Percent of Time: _____</p> <p>Surface: _____</p> <p>Distance: _____</p>	<p>Hours at One Time: 0 1 2 3 4 5 6 7 8</p> <p>Total Hours in 8-Hour Day: 0 1 2 3 4 5 6 7 8</p>
<p><b><u>DRIVING</u></b></p> <p>Percent of Time: _____</p>	<p>Hours at One Time: 0 1 2 3 4 5 6 7 8</p> <p>Total Hours in 8-Hour Day: 0 1 2 3 4 5 6 7 8</p>

**APPENDIX A (Continued)**

**TASK/JOB ANALYSIS (CONTINUED) FOR TASK/JOB TITLE:**

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<b>FOR FREQUENCY/PERCENT OF TIME, USE THE FOLLOWING SCALE</b>			
<b>Continuously (67 - 100%) (5 - 8 hour/8 hour day)</b>	<b>Frequently (34 - 66%) (2.5 - 5 hour/8 hour day)</b>	<b>Occasionally (6 - 33%) (30 min - 2.5 hour/8 hour day)</b>	<b>Rarely (1 - 5%) (0-30 min/8 hour day)</b>

<b><u>CAN WORKER CHANGE POSITIONS?</u></b>			
<b><u>LIFTING</u></b>			
Weight:	Type of Object:	Overhead Lifting:	Frequency:
<b><u>CARRYING</u></b>			
Weight:	Type of Object:	Frequency:	Distance:
<b><u>PUSHING/PULLING</u></b>			
Weight:	Type of Object:	Times Per Hour:	Distance:
<b><u>REACHING/HANDLING</u></b>			
<b>AT/ABOVE SHOULDER:</b>	Right/Left or Both: _____	Distance: _____	
	Overhead Reaching: _____	Frequency: _____	
<b>BELOW SHOULDER:</b>	Right/Left or Both: _____	Distance: _____	
	Overhead Reaching: _____	Frequency: _____	
<b><u>BENDING/SQUATTING</u></b>			
Frequency: _____	From Waist: _____	Knees: _____	Duration: _____
<b><u>TWISTING</u></b>			
From What Body Part? _____		Frequency: _____	
How Far? _____	Work Being Done: _____		
<b><u>CLIMBING</u></b>			
Height: _____	Slope: _____	Number of Steps: _____	Frequency: _____
On What? _____		Ladder? _____	
<b><u>SAFETY EQUIPMENT NEEDED (Personal Protective Equipment)</u></b>			
<b><u>ENVIRONMENTAL STRESSORS – MACHINES/TOOLS/EQUIPMENT (used as part of the task/job)</u></b>			

# Accident Investigation FORMS

## HOW TO USE THESE IMPORTANT TOOLS

### Includes:

Employee's Report  
of Injury Form

Accident Witness  
Statement Form

Supervisor's  
Accident  
Investigation Form

*Forms may be copied as  
needed.*

*Forms are also available for  
printing in pdf format online at  
[www.iwif.com](http://www.iwif.com).*



### Need Help?

If you would like assistance in setting up supervisory training on how to use these forms, please contact your IWIF Claims Adjuster or Loss Control Consultant at 1-800-264-IWIF.

Accident investigation forms/statements **should be filled out** by the **injured employee, supervisor and any witness** to the accident. Train your supervisors to conduct the preliminary investigation as soon as possible.

**IMPORTANT** – Care must be taken to assure the investigation is fact finding, not fault finding. Obtaining signed statements as soon as possible following an accident insures that you, the employer, have an accurate account of how the injury occurred. These completed statements are important in helping to correct hazards and prevent the accident from recurring. They also help to spot possible third-party liability as well as possible fraudulent claims, which can help defend against the claim.

### After I have these forms completed – what do I do with them?

Please send the completed forms to your IWIF Claims Adjuster and keep a copy for your files. These completed forms can provide valuable information in a claims investigation of an injury and for developing the defense in the event of a workers' comp hearing.

### What if my injured employee is physically unable to fill out the Employee's Report of Injury?

Use common sense and good judgement. If the injury is severe – remember your employee's health and care is first and foremost. If possible, have the form filled out at a later, more appropriate time when the employee is physically able to document the accident.

### What if my employee refuses to fill out or sign an Employee's Report of Injury?

Of course, you cannot make an employee fill out the document. You can, however, stress the importance of getting "their" account of the accident to help prevent the injury from happening again. Also, still obtain the supervisor's report as well as any witness statements.

### What if my Employee has retained an attorney – Can I still ask the injured employee to fill out an Employee's Report of Injury?

Yes – you, the employer as part of your company's accident management plan, can still ask the employee to fill out the report form.

APPENDIX B (Continued)

IWIF

# Employee's Report of Injury

(To be completed by the employee only.)

Employee's name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Date of birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Home telephone # (\_\_\_\_\_) \_\_\_\_\_  
Last First Middle

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Present classification: \_\_\_\_\_ How long employed here: \_\_\_\_\_

Social Security No.: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ Weekly salary: \_\_\_\_\_

Location of accident: \_\_\_\_\_  
Address Area (loading dock, bathroom, etc.)

Date of accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_

Describe fully how accident occurred: (including events that occurred immediately before the accident):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe bodily injury sustained (be specific about body part(s) affected): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Recommendation on how to prevent this accident from recurring: \_\_\_\_\_

\_\_\_\_\_

Name of supervisor: \_\_\_\_\_ Phone# \_\_\_\_\_  
Last First

Name(s) of witness(es): \_\_\_\_\_ Phone# \_\_\_\_\_  
(Attach witness(es) report(s))

When did you report the accident to your supervisor? \_\_\_\_\_

To whom did you report the injury? \_\_\_\_\_

Do you require medical attention? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Maybe: \_\_\_\_\_

Name of your treating physician: \_\_\_\_\_ Phone# \_\_\_\_\_

Signature of employee: \_\_\_\_\_ Date: \_\_\_\_\_

IWIF

# Accident Witness Statement

(To be completed by accident witness)

Injured employee's name: \_\_\_\_\_  
Last First Middle

Name of witness: \_\_\_\_\_ Ph# \_\_\_\_\_  
Last First Middle

Job title of witness: \_\_\_\_\_ How long employed here? \_\_\_\_\_

Home address of witness: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Location of accident: \_\_\_\_\_  
Address/Name of building Area (bathroom, etc.)

Date of accident: \_\_\_\_\_ Time of accident: \_\_\_\_\_

Describe fully how accident occurred: (including events that occurred immediately before the accident):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe bodily injury sustained (be specific about body part(s) affected): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Recommendation on how to prevent this accident from recurring: \_\_\_\_\_

\_\_\_\_\_

Name of Witness' Supervisor: \_\_\_\_\_ Ph# \_\_\_\_\_  
Last First

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_



APPENDIX B (Continued)

IWIF

# Supervisor's Accident Investigation

(To be completed by the employee's supervisor or other responsible administrative official)

Location where accident occurred:		Employer's Premises: Yes No Job site: Yes No	Date of accident:
Who was injured?		Employee Non-Employee	Time of accident: a.m. p.m.
Length of time with firm:	Job title or occupation:	Name of dept. normally assigned to:	How long has employee worked at job where injury occurred?
What property/equipment was damaged?			Property/equipment owned by:
What was employee doing when injury occurred? What machine or tool was being used? What type of operation? _____			
How did injury occur? List all objects and substances involved. _____ _____ _____			
Part of body affected/injured?		Any prior physical conditions? If so, what? Yes No	
Nature and extent of injury and property damaged (be specific) _____ _____			

**PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Failure to lockout   | <input type="checkbox"/> Improper maintenance          | <input type="checkbox"/> Poor housekeeping             |
| <input type="checkbox"/> Failure to secure    | <input type="checkbox"/> Improper protective equipment | <input type="checkbox"/> Poor ventilation              |
| <input type="checkbox"/> Horseplay            | <input type="checkbox"/> Inoperative safety device     | <input type="checkbox"/> Unsafe arrangement or process |
| <input type="checkbox"/> Improper dress       | <input type="checkbox"/> Lack of training or skill     | <input type="checkbox"/> Unsafe equipment              |
| <input type="checkbox"/> Improper guarding    | <input type="checkbox"/> Operating without authority   | <input type="checkbox"/> Unsafe position               |
| <input type="checkbox"/> Improper instruction | <input type="checkbox"/> Physical or mental impairment | <input type="checkbox"/> Other _____                   |

Supervisor's corrective action to ensure this type of accident does not recur: \_\_\_\_\_

Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedures? Yes \_\_\_ No \_\_\_

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedures? Yes \_\_\_ No \_\_\_

Did employee promptly report the injury? Yes \_\_\_ No \_\_\_

Is there modified duty available? Yes \_\_\_ No \_\_\_

\_\_\_\_\_  
Supervisor's name                      Supervisor's signature                      Phone#                      Date

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Form may be copied as needed

APPENDIX C

**PHYSICIAN'S MEDICAL ASSESSMENT OF EMPLOYEE**

Page 1 of 2

The State of Maryland has a **Managed Return-to-Work Program** designed to facilitate the earliest possible return of employees with work-related injuries to meaningful, productive work that is within their medical capabilities. The Program provides temporary transitional duty assignments that allow employees to progressively assume more demanding work tasks until they are able to return to full pre-injury duty. **Please assist us by indicating on the attached form your medical assessment of our employee.** The information that you provide will help us to work with the employee to achieve a prompt return to suitable work.

If you have any questions regarding the Program or the employee's return-to-work status, please contact the agency contact shown on the top of the attached form.

**THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE EMPLOYEE:**

**Authority to Release Medical Information:**

I authorize \_\_\_\_\_(medical provider) to release medical information, including medical records to \_\_\_\_\_(agency contact) regarding my work-related injury that occurred on \_\_\_\_\_(date) or any injury arising out of the aforementioned injury, for the purpose of assessing my ability to return to work and my eligibility for leave and compensation, and for developing appropriate transitional duty assignments.

**Right to Revoke:**

I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this authorization will expire one (1) year after the date on which the authorization is signed. To revoke the authorization, I must write to: Kim Scott, Department of Budget and Management (DBM), Office of Personnel Services and Benefits (OPSB), 301 West Preston Street, Room 609, Baltimore, MD 21201 or by fax at 410-333-5262.

**Authorization and Signature:**

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws limiting the use and/or disclosure of my confidential protected health information.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

## APPENDIX C

### PHYSICIAN'S MEDICAL ASSESSMENT OF EMPLOYEE

Page 2 of 2

To be completed by Employer:

Employee Name:	Employee Phone Number:
Agency/Unit:	IWIF Claims Number:
Agency Contact Name:	Agency Contact Phone Number:

To be completed by Employee's Treating Physician:

#### ASSESSMENT OF EMPLOYEE'S CAPABILITIES

ACTIVITIES	Constantly (67%-100%)	Frequently (34%-66%)	Occasionally (0%-33%)	Not at all	
BENDING					
SQUATTING					
CLIMBING					
TWISTING					
CRAWLING					
BALANCING					
KNEELING					
LIFTING/CARRYING	Constantly (67%-100%)	Frequently (34%-66%)	Occasionally (0%-33%)	Not at all	
0-10 lbs					
11-20 lbs					
21-50 lbs					
51-100 lbs					
Over 100 lbs					
	Pushing/Pulling	Grasp/Lift/Carry	Finger/Feel	Reach Up	Use Feet
RIGHT	YES NO	YES NO	YES NO	YES NO	YES NO
LEFT	YES NO	YES NO	YES NO	YES NO	YES NO

REPETITIVE MOTIONS INCLUDING KEYBOARDING:				
Right Hand/Wrist	_____ minutes/hour	_____ total hours	_____ no restrictions	
Left Hand/Wrist	_____ minutes/hour	_____ total hours	_____ no restrictions	

ENDURANCE: Please indicate the number of hours per day that these activities should be limited to.								
HOURS	1	2	3	4	5	6	7	8
SIT								
STAND								
WALK								
DRIVE								

This patient may work a total of \_\_\_\_\_ hours per day, and a total of \_\_\_\_\_ days per week.

Date of Injury: \_\_\_\_\_

Date of Initial Exam: \_\_\_\_\_ Date of Next Appointment: \_\_\_\_\_

Prognosis, Treatment Plan & Anticipated MMI date (attach additional pages as needed):
---

Physician's Signature & Credentials: \_\_\_\_\_ Date: \_\_\_\_\_

APPENDIX D

TRANSITIONAL JOB OFFER LETTER

(Use Agency Letterhead)

(CERTIFIED - RETURN RECEIPT AND REGULAR MAIL)

(Date)

(Employee name and mailing address)

Re: Offer of Transitional Employment

Dear (Employee Name):

We have reviewed the Medical Assessment of Employee form completed by your physician and are pleased to offer you the following transitional work assignment. We believe this assignment is within your capabilities as described on the attached form by your physician. Your assigned tasks will be consistent with your medical restrictions, skills and knowledge. We will provide any training that may be required to do this assignment.

Description of transitional duty assignment: \_\_\_\_\_

Description of physical demands of this assignment: \_\_\_\_\_

Duration of assignment: \_\_\_\_\_ (total work days) beginning: \_\_\_\_\_ ending: \_\_\_\_\_

Days of the week employee will work: \_\_\_\_\_

Work hours: From: \_\_\_\_\_ To: \_\_\_\_\_

Pay rate (same as regular rate): \$ \_\_\_\_\_ per \_\_\_\_\_

Department: \_\_\_\_\_ Division/Unit: \_\_\_\_\_

Supervisor during transitional duty assignment: \_\_\_\_\_

**This job offer will remain open for 5 working days following your receipt of this letter (per returned receipt), or 5 working days from the date the letter was sent by regular mail. If we do not hear from you within 5 working days, we will assume that you have declined this offer. Please be advised that declining a transitional work assignment may have an adverse impact on the benefits to which you might otherwise be entitled.**

We look forward to your return to work. If you have any questions, please do not hesitate to contact me on (phone number).

Sincerely,

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

- I accept this transitional duty assignment       I decline this transitional duty assignment

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DBM/RTW3