Early and Safe Return to Work Policy

Policy Number:	08-001
Approved by:	County Council
Department:	All Departments
Date Approved:	2018-09-05
Effective Date:	2018-09-05
Originating Department:	Management Team
Last Revision Date:	2008-01-16
Scheduled for Review By:	2023-01-02
Replaces Policy No:	N/A

1.0 Purpose

1.1 To provide clear, consistent and equitable early and safe return to work programs for both occupational and non-occupational disabilities, injuries, and illnesses enabling the Corporation of the County of Essex to meet the legislative requirements outlined in the Workplace Safety and Insurance Act (WSIB), the Ontario Human Rights Code, Employment Standards Act and the Ontarians with Disabilities Act.

1.2 Should an employee become injured or ill and unable to perform regular duties, the Corporation supports the concept of Early and Safe Return to Work programs, which enables employees to be reintegrated back into the workforce as soon as possible.

2.0 Policy

2.1 The Corporation of the County of Essex will provide, when and where it deems it possible, a timely modified Return to Work program as appropriate and feasible for all employees with medically documented restrictions (or appropriate standard WSIB restrictions) or physical and/or mental capabilities resulting from injuries and illnesses.

3.0 Scope

3.1 This policy applies to all employees of all departments, divisions or sections of the Corporation.

4.0 Definitions

4.1 Roles and Responsibilities

Return to Work Program Coordinator: The Corporation will assign one or more non-union employee(s) in a leadership position with training in Return to Work issues to co-ordinate this activity.

a) Contact the employee as soon as practicable following receipt of an incident, injury or accident report to expedite the licensed health care provider's estimation of the duration of absence and or period of modified work.

b) In accordance with absence duration thresholds noted in this policy, ensure that all the necessary paperwork has been completed (including that as required to be completed by the health care provider); arrange for Physical Demands Analysis (PDA) and Functional Abilities Form (FAF) to be provided to the employee.

c) Meet with the employee/union to develop specific goals and objectives for each case.

d) Involve the immediate manager/supervisor/union in the employee's return to work plan.

e) Monitor progress of employees in the programs and maintain regular communication with Senior Management, to ensure a successful outcome.

f) Maintain communication with all parties involved to ensure consistency and accuracy of information.

g) Review (at least monthly) all current employees on short-term disability to determine eligibility for these programs.

h) Present in-service training to all employees/staff.

i) Regular communications with the WSIB (if applicable).

j) If applicable, completing the necessary documents for the WSIB.

k) Keeping the union informed of program status.

l) Inform the LTD carrier of both WSIB and STD absences that have exceeded ten (10) weeks in duration.

m) Ensure that confidential medical information is controlled in accordance with government legislation.

4.2 **Employee:**

a) Report any incident or illness to your immediate supervisor/manager as soon as practicable and maintaining communication throughout your period of recovery.

b) Complete necessary paper work with the Return to Work Program Coordinator or designate before leaving that shift, if possible. Otherwise, forward the completed paperwork as soon as practicable.

c) When requested or in accordance with this policy, obtain medical approval from licensed health care provider for the Early and Safe Return to Work programs utilizing the Functional Ability Forms (Appendices D & E)and return to the Return to Work Program Coordinator as quickly as possible.

d) Participate and cooperate in the Early and Safe Return to Work program by maintaining personal and regular contact with the Return to Work Program Coordinator regarding physical capabilities and treatment plans as is reasonable in the circumstances of the case in question.

e) Ensure other scheduled treatments such as physiotherapy are continued in conjunction with the return to work plan.

f) Communicate any concerns to Supervisor and Return to Work Program Coordinator so that potential problems are openly addressed and resolved.

g) Meet job requirements of modified work program.

h) Work safely

4.3 **Employee's Direct Manager/Supervisor:**

a) Develop knowledge and understanding of Early and Safe Return to Work programs and Disability Management.

b) Investigate injury or complaint and ensure immediate completion of incident/accident report(s) and submit to Return to Work Program Coordinator.

c) Participate in the promotion of the Early and Safe Return to Work programs and provide ongoing support to those employees involved in the program.

d) Assist with the physical demands analysis for job descriptions.

4.4 **CAO**

a) Appoint a Return to Work Program Coordinator for each department of the Corporation, who is knowledgeable, experienced and/or trained in RTW/Disability Management, to develop, monitor and administer the Return to Work (RTW) Program.

b) Support the development of the RTW Program ensuring it is fair and consistently applied for all employees.

c) Allocate human and financial resources for the administration of the RTW Program.

d) Provide training and education to all managers, supervisors and employees regarding the RTW Program.

e) Participate in the identification and implementation of meaningful accommodations as required.

f) Support the continuous improvement of the RTW Program.

g) Provide a safe work environment.

4.5 **Fellow Employees**

a) Support the RTW plans of employees.

b) Contribute to a supportive and respectful work environment.

4.6 **Union (where applicable)**

a) Provide visible support for the RTW program.

b) Assist with the identification of RTW accommodations.

c) Support the employee during the RTW process.

d) Ensure employee rights are protected during the RTW process.

5.0 How to Report a Work Place Injury

5.1 All employee are to report any injury / illness to their supervisor immediately or as soon as is reasonable.

5.2 If the employee requires health care treatment for a work-related injury/condition, the supervisor will provide the employee with a Return to Work Package (employee information sheet, licensed health care provider(s) letter, and Functional Abilities Form (FAF)) and instruct the employee to take the letter and FAF to their licensed health care provider.

5.3 Immediately following initial health care treatment, the employee will provide copies of page 2 of the completed Form 8 or FAF and meet with or contact the Return to Work Coordinator and supervisor to discuss return to work options.

5.4 If the employee is unable to return to work the same day after receiving their health care treatment due to functional/cognitive limitations or the duration of receiving health care treatment has exceeded the hours of their regular scheduled shift, copies of page 2 of the completed Form 8 or FAF are to be provided the following work day and the supervisor and Return to Work Program Coordinator are to be contacted to discuss return to work options.

5.5 Where functional/cognitive abilities information supports an immediate return to work with or without accommodation, employees should be prepared to resume work the same day or at their next scheduled shift, if the same day shift has ended.

5.6 If the employee is unable to return to work immediately, the supervisor/Return to Work Program Coordinator must be notified. The Return to Work Program Coordinator is to establish initial supportive contact (with the employer and direct supervisor) within 24 hrs and follow up weekly or as needed depending on the employee's specific situation and medical information throughout the employee's recovery process. Each contact or attempt will be documented on the contact log. Note that the contact frequency may vary depending on the nature and severity of the injury/illness.

5.7 The Return to Work Program Coordinator will complete the WSIB Form 7; Employer's Report of Injury, within 3 days of learning of a workplace injury/illness and submit the form to the WSIB.

6.0 References:

- Employment Standards Act (ESA)
- Human Rights Code
- Ontarians with Disabilities Act
- Workplace Safety and Insurance Act
- Appendix A – WSIB Medical Advisor Table of Standard Restrictions

7.0 Explanation

7.1 **Absence Monitoring:**

7.1.1 When absent from work due to any kind of illness or injury, employees will provide all medical notes required in accordance with all appropriate collective agreements, Corporation policies, the Workplace Safety and Insurance Act, and insurance company requirements.

7.1.2 In situations where the employee has a non-occupational illness and the absence will be more than one (1) calendar week in duration, and/or when deemed appropriate by the Corporation due the nature of the ailment or timing, the Corporation may request that employee have the appropriate Functional Abilities Form completed by the employee's licensed health care provider. In situations where the employee has a non-occupational injury, the employee will be required to provide, as a minimum, a certificate from their licensed health care provider, supporting the injury related inability to work-in their own occupation. The Corporation may also request in the case of injury that the employee provide additional medical documentation (including by way of the Functional Abilities Form). Should the employee not provide the required certification or additional documentation within the time frame required by the Corporation, the employee may be deemed to no longer qualify for Short Term Disability coverage subject to the appropriate collective agreement.

7.1.3 In the situation where the Corporation has concerns related to the information in an employee's Functional Abilities Form or other medical documentation, it may forward it for review to an external health care-related agency for their review and recommendation. Should the external health care-related agency not agree with the findings of the medical documentation, or should the Corporation so direct the agency, upon receiving a signed voluntary release from the employee, it shall contact the licensed health care provider who has completed the medical documentation to seek clarification.

7.1.4 In cases of an outbreak as declared by the Medical Officer of Health, time frame requirements outlined in this policy will be reviewed by the Corporation to determine if it is appropriate to change time frames.

7.2 **Program:**

7.2.1 The purpose of short term disability programs is to provide some form of compensation for specified periods of time for employees who are completely disabled from working due to a non-occupational illness or injury. Cases where employees have medically documented restrictions resulting from illnesses or injuries which limit, but do not totally prevent some form of work from being done, will be considered by the Corporation for participation in the Modified Return to Work program.

7.2.2 Employees who are eligible for participation in this program and elect not to participate may not be eligible for compensation under the Short Term Disability plan for their employee group, and may be considered to be absent without leave (AWOL), as determined by the Corporation in the circumstances.

7.2.3 Preference will be to accommodate an employee in their own role; failing that within their department; and ultimately within any department within the Corporation of the County of Essex. Accommodation may also assist other employees, but will not take the place of a regularly scheduled employee who would otherwise be available to work.

7.3 Ensuring Suitable Accommodations:

7.3.1 The determination as to whether or not an employee can perform the essential duties of the job is the responsibility of the Return to Work Program Coordinator, in conjunction with the licensed health care provider.

7.3.2 The following procedure will be used, once the Return to Work Program Coordinator or designate receives notice from the applicable supervisor that an employee is not capable of returning to his or her regular duties, at the onset of the injury or disease/disability that is anticipated to extend beyond one calendar week:

7.3.3 The Return to Work Program Coordinator will follow up with the supervisor/manager to ensure the appropriate Corporation Functional Abilities Form (FAF) or WSIB Functional Abilities Form (FAF) has been forwarded for review.

7.3.4 The Return to Work Program Coordinator or designate will initiate return to work discussions involving the employee and the employee's supervisor as soon as practicable. The discussions may be in person or over the telephone. Where appropriate union representation will be invited.

7.3.5 The Return to Work Program Coordinator and the employee will review the Physical Demands Analysis (PDA) of the pre-injury position and determine if it is within his/her physical or mental restrictions, as outlined in the Functional Abilities Form (FAF).

7.4 Standard Restrictions

7.4.1 Where appropriate, in developing a return to work program for those employees with injuries or illnesses, the Program Coordinator may have regard for the WSIB unit medical advisor Standard Restrictions (Appendix A).

7.4.2 When the employee is medically ready to increase duties, all parties (employee, supervisor, Return to Work Program Coordinator) will meet again to develop the specific tasks, the hours to be worked and the time frames of the program.

7.4.3 Follow-up meetings will be scheduled as required if there is a need to modify or extend the Modified Return to Work program.

7.5 Monitoring Progress

7.5.1 All employees participating in Early and Safe Return to Work Programs will complete Modified Work Activity Sheets where

appropriate. The sheets will identify the individual's level of functionality and associated comfort with the activities assigned.

7.5.2 In rare instances where agreement between all parties cannot be reached on a Modified Work Plan, further medical documentation will be required from a licensed health care provider. It is understood that in some cases the employee will be requested to attend to a third party licensed health care provider agreed upon jointly by the Corporation (or representatives of disability claims management firms contracted by the Corporation) and the employee. Charges levied by the licensed health care provider will be paid for by the Corporation.

7.5.3 At the conclusion of the Modified Work Plan the employee will be required to present an updated FAF or where appropriate, medical certification from the licensed health care provider, documenting that the employee is capable to return to full duties or that a revised Modified Work Plan is required.

7.5.4 For part-time or casual employees working modified duties (in a full time or part time position), the normal hours of work for the purposes of establishing a Modified Return to Work Plan, will be the approximate average of the previous sixteen (16) weeks that employee worked.

7.5.5 An employee who works on a Modified Return to Work Program shall adhere to the work schedule associated with that program, unless mutually agreed upon by the parties to maintain the schedule of the pre-injury role. For example; modified duties may end up being Monday to Friday days even though their regular schedule would rotate through a 24/7 schedule.

7.5.6 Employee's compensation will be administered under their applicable STD/LTD or WSIB plan for hours not worked, but would have normally been worked if not for being on a Modified Work Program.

7.5.7 There may be cases where Modified Return to Work Programs are not available within an employee's bargaining unit, but are available in other areas of the Corporation. In accordance with Human Rights legislation, such cases will be handled on a case-by-case basis in consultation with Human Resources the department head, and any applicable Union(s) executives/ stewards. In cases where appropriate modified duties are not available, the employee will revert to the applicable WSIB, STD, or LTD program.

7.6 Non-Occupational Injury

7.6.1 In situations where the employee has a non-occupational injury, when deemed appropriate by the Corporation due to the nature of the injury or timing, the employee may be required to have the appropriate Functional Abilities Form completed by the employee's licensed health care provider on an appropriately regular basis.

7.6.2 Should the employee not provide the required certification or additional documentation within the time frame required by the Corporation, the employee may be deemed to no longer qualify for Short Term Disability coverage subject to the appropriate collective agreement or Corporate policy particularly for non-union employees.

8.0 Dispute Resolution Process

8.1 In situations where there are concerns or disputes related to the RTW Plan or process, the workplace parties will use the following procedure.

8.2 Disputes may arise from, but are not limited to:

- suitability of assigned tasks, tools or equipment,
- functional and cognitive abilities,
- lack of progression of recovery, and
- safety concerns.

8.3 The resolution of disputes will be addressed in the following manner:

8.3.1 Employee must notify the supervisor of their light duty assignment or the Return to Work Program Coordinator of the concern or dispute. The employee is encouraged to identify potential solutions. Concerns/disputes will be documented on the Modified Work Activity Sheet.

8.3.2 The supervisor will investigate the concern and discuss possible solutions with the employee. If both parties are in agreement, the

solution is implemented and the RTW Plan is updated. A copy of the revised plan is provided to the applicable Return to Work Program Coordinator.

8.3.3 If the concern is not resolved, the Supervisor must notify the Return to Work Program Coordinator and the union (If applicable)

8.3.4 The Return to Work Program Coordinator investigates the concern and considers possible solutions with the employee, the Supervisor and the union representative (where applicable).

8.3.5 If all parties are in agreement, the solution is implemented and the RTW Plan is updated.

8.4 The dispute resolution process may require the Return to Work Program Coordinator to:

a) Seek clarification or input from the employee's licensed health care provider(s).

b) Seek clarification or input from the WSIB or STD/LTD Case Manager.

c) Refer the employee for an independent medical examination (IME).

d) Refer the employee for a functional abilities evaluation (FAE) or cognitive abilities evaluation.

e) Request an ergonomic assessment.

f) Request a referral to a WSIB RTW Specialist or Work Transition Specialist to facilitate a resolution (occupational cases only).

8.5 If the employee's concern or dispute is not resolved, the employee may:

a) Pursue an appeal with the WSIB or STD/LTD insurer.

b) Initiate a grievance (unionized employees only).

c) Pursue a complaint with the Ontario Human Rights Commission.

9.0 Program Evaluation

9.1 Each Return to Work Program Coordinator will prepare an annual RTW Program evaluation report. They will present this report to their respective leadership team. This information will be consolidated on a corporate wide bases and presented by the Director of Human Resources to corporate senior management. It will include the following information:

a) total number of WSIB, STD and LTD claims;

b) total number of WSIB, STD and LTD lost time days;

c) total number of accommodated days for occupational and non-occupational disabilities;

d) total accommodation costs including benefit costs paid by employer;

e) the total number of RTW plans resulting in the following outcomes:

- regular duties with no accommodation,
- regular duties with accommodation,
- alternate job with no accommodation,
- alternate job with accommodation, or
- leave of absence.

f) summary of supervisor suggestions for program improvement;

g) summary of employee suggestions for program improvement;

h) recommendations for program improvement;

i) recommendations for budget allocation.

9.2 The senior management team, in collaboration with the Director of Human Resources and the Return to Work Program Coordinators will establish a budget for the RTW Program, develop objectives for continuous improvement and implement an action plan that includes:

a) defined objectives,

b) assignment of responsibilities for each objective, and

c) target dates for completion.

10.0 Appendices

- Appendix A: Standard Restrictions

- Appendix B: Modified Return to Work Activity Program
- Appendix C: Modified Return to Work Activity Sheet
- Appendix D: Functional Abilities Form (Physical) for Timely Return to Work non work related (for work related injuries use the WSIB issued forms)
- Appendix E: Functional Abilities Form (Mental) for Timely Return to Work non work related (for work related injuries use the WSIB issued forms)
- Appendix F: Return to Work Closure evaluation Report – Employee
- Appendix G: Return to Work Closure Report – Supervisor
- Appendix J: Incident Report

Appendix A: Standard Restrictions

The below notes the area of injury with the corresponding restriction;

Back

No repetitive trunk movement (bending & twisting)

No heavy lifting (more than 10kg)

No prolonged weight bearing which includes sitting, standing and walking (must have ability to frequently change position i.e. sit or stand)

Neck

No repetitive neck movement

No above shoulder and overhead activity

Shoulder

No repetitive (R/L) shoulder movement

No heavy lifting (more than 10kg)

No above shoulder activity

No repetitive use of the (R/L) upper extremity against resistance (pushing and pulling)

Upper Extremity (including elbow, wrist and hand)

No repetitive movement of the involved joint against resistance (pushing and pulling)

No lifting over 10 kg

For the hand and wrist, this should also include no repetitive gripping

Lower Extremity (including hip, knee, ankle and foot)

No repetitive movement of the involved joint against resistance

No prolonged weight bearing

No prolonged standing (greater than 15 minutes without opportunity for change of position)

No rough ground walking

No low level activity and climbing

No ladder climbing

Should have the ability to change positions as required (sit or stand)

These restrictions should be used when the treating licensed health care provider has not provided functional ability information. These restrictions are based on information obtained from the WSIB Medical Advisory Services. These restrictions can be further modified if required.

Appendix B: Modified Return to Work Program

Employee Name:

First Day of Modified Duties:

Last Day of Modified Duties:

Injury/Illness Date:

Immediate Manager/Supervisor Name:

Union Steward Name:

Welcome back to work following your illness or injury. We are in receipt of the Functional Abilities Form (FAF), completed by your health care provider. This information supports your participation in our Return to Work Program. The objective of this program is to safely transition you back to full duties.

Please List Modified Tasks

It is your responsibility to work within your capabilities. Please report to your immediate Manager/Supervisor as soon as is practical if you have any difficulty completing job tasks or any reoccurrence of symptoms.

All appointments with your health care providers should be scheduled outside of normal work hours. However, upon request, your immediate manager/supervisor will work with you to alter your schedule to accommodate appointments. If you are unable to attend an appointment, please notify your immediate manager/supervisor immediately.

Attach a per week schedule if required.

Date (yyyy-mm-dd):

Signatures

Employee Signature

Union Steward Signature (where applicable)

Immediate Manager/Supervisor

Appendix C: Weekly Modified Return to Work Activity Sheet

Employee Name:

Department:

Time of Shift:

Week of : (yyyy-mm-dd to yyy-mm-dd))

Supervisor Signature

Work Activities – List Areas and Task	Duration of Time for Each Task	List Any Pain After Task – i.e. Pain Tolerance	Other Comments

Appendix D:

Functional Abilities Form (FAF) Non-Occupational

A

Functional Abilities Form is used to assist The Corporation of the County of Essex in the accommodation process of an injured/ill employee by facilitating an early and safe return to work.

1. Employee Information (To be completed by the employee)	
Name	Job Position
Department	Date
I hereby authorize the release of this medical information to the Corporation of the County of Essex for the purpose of supporting my early and safe return to work.	Employee Signature

2. To be completed by Healthcare Professional			
Date of Exam	☐ Initial Assessment	☐ Follow-up Appointment	Nature of Ailment
☐ Employee is capable of returning to **REGULAR DUTIES**	☐ Employee capable of returning to **MODIFIED DUTIES**	☐ Employee is **UNABLE** to return to any work.	

3. Physical Abilities (Please indicate abilities below)			
Standing: ☐ Full abilities ☐ Less than 30 minutes ☐ Less than 15 minutes ☐ Other (please specify)	Walking: ☐ Full abilities ☐ Less than 30 minutes ☐ Less than 15 minutes ☐ Other (please specify)	Sitting: ☐ Full abilities ☐ Less than 30 minutes ☐ Less than 15 minutes ☐ Other (please specify)	Lifting: floor to waist: ☐ Full abilities ☐ Less than 20 kg ☐ Less than 10 kg ☐ Other (please specify)
Lifting: waist to shoulder ☐ Full abilities ☐ Less than 20 kg ☐ Less than 10 kg ☐ Other (please specify)	Stair climbing: ☐ Full abilities ☐ 5-10 steps ☐ Up to 5 steps ☐ Other (please specify)	Ladder climbing: ☐ Full abilities ☐ 4-6 steps ☐ 1-3 steps ☐ Other (please specify)	Transportation: Capable of operating a motorized vehicle: ☐ Yes ☐ No

4. Specific Limitations (Please indicate abilities below)				
☐ Bending/ twisting/ repetitive movement of:	☐ Above shoulder activity	☐ Below shoulder activity	☐ Operating motorized equipment	☐ Limited use of hand(s): Left Right ☐ Gripping ☐ ☐ Pinching
☐ Restrictions related to medications	☐ Chemical Exposure	☐ Environmental Exposure	☐ Exposure to vibrations	☐ Limited pushing/pulling ☐ Left arm ☐ Right arm

5. Additional Comments on Abilities/ Limitation/ Restrictions:

6. Return to Work Plan			
These restriction will apply for approximately: ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 14+ days		Recommended Work Hours: ☐ Full time ☐ Modified ☐ Graduated _____	
Start Date	Estimated Return to Modified Duties	Estimated Return to Regular Duties	Date of Next Appointment

7. Signature	
Healthcare Professional Name	Date
Signature	Telephone

Appendix E:

Cognitive Abilities Form
Non-Occupational

A Functional Abilities Form is used to assist The Corporation of the County of Essex in the accommodation process of an injured/ill by facilitating an early and safety return to work.

1. Employee Information (To be completed by the employee)	
Name	Job Position
Department	Date
I hereby authorize the release of this medical information to the Corporation of the County of Essex for the purpose of supporting my early and safe return to work.	Employee Signature

2. To be completed by Healthcare Professional (Please check all that apply)			
Date of Exam	Nature of Ailment	☐ Initial Assessment	☐ Follow-up Assessment
☐ Employee is capable of returning to **REGULAR DUTIES**	☐ Employee capable of returning to **MODIFIED DUTIES**	☐ Employee is **UNABLE** to return to any work.	

4. Evaluation of Functional Capacity					
I: Improvement **R**: Regression **N/C**: No Change **N/A**: Not Applicable	Please rate the degree of functional impairment: 0- None 1 to 3- Mild 4 to 7- Moderate 8 to 10- Severe				
Cognitive Abilities	**I**	**R**	**N/C**	**N/A**	**Impairment Rating**
Ability to self-supervise and/or supervise others					
Ability to attend to detail (attention/memory)					
Ability to perform multiple tasks					
Ability to manage stressful and/or emotional situations					
Ability for decision making, organizing and planning					
Ability to work co-operatively with others					
Ability to exercise judgment					
Ability to tolerate environmental/distracting stimuli					
Ability to work with the public					
Ability to communicate (verbal/written/comprehension)					

5. General Description of Precipitating Events (if applicable):

6. Pre-existing condition and/or complicating factors that may impact ailment:

7. Describe any potential psychological triggers/restrictions for this employee:

8. Will this employee benefit from hierarchical exposure during their return to work process? If yes, please explain.

9. Do you have any safety concerns regarding this employee within or outside of the workplace? If yes, please specify the concern and the steps required to assure employee safety.

10. If the employee is unable to return to work due to injury/illness, what would need to be in place for the employee to return to work in any capacity:

11. Additional Comments on Cognitive Abilities/ Limitation/ Restrictions:

12. Return to Work Plan			
These restriction will apply for approximately: ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 14+ days		Recommended Work Hours: ☐ Full time ☐ Modified ☐ Graduated _____	
Start Date	Estimated Return to Modified Duties	Estimated Return to Regular Duties	Date of Next Appointment

13. Signature

Healthcare Professional Name	Date
Signature	Telephone

Appendix F:

RETURN TO WORK CLOSURE EVALUATION REPORT–EMPLOYEE

Employee Name:	Department:
Occupation:	Supervisor Name:
Date of Injury/Disability:	Claim No. (WSIB, STD, LTD):
Plan Start Date:	Plan End Date:

q Returned to an alternate job

q Returned to an alternate job with accommodation

q Applied for STD/LTD benefits

q Applied for WSIB benefits

q Retraining – STD/LTD Insurer

q Retraining - WSIB

QUESTION	YES	NO	N/A
1. Did the Return to Work Coordinator provide information regarding benefits and services available under the company's benefits and RTW programs? Comments:	q	q	q
2. Did you experience any challenges or concerns with your RTW Plan? Comments:	q	q	q
3a. Did your supervisor resolve your concerns with the RTW Plan in a timely manner? Comments:	q	q	q
3b. Did you bring forward your challenges or concerns to your supervisor or RTW Program coordinator?			

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QUESTION	YES	NO	N/A
4. Did the Return to Work Coordinator resolve your concerns with the RTW Plan in a timely manner? Comments	q	q	q
5. In your opinion, was your supervisor supportive of your Return to Work Plan? Comments	q	q	q
6. In your opinion, were your co-employees supportive of your Return to Work Plan? Comments	q	q	q
7. Was your overall experience with the RTW program positive? Comments	q	q	q
8. Do you have any suggestions to improve the company's Return to Work program? Comments:	q	q	q

Employee Signature:	Date:

Thank you for providing valuable feedback on your experience with the Return to Work Program. Your feedback will be used to improve the company's Return to Work Program.

Appendix G

RETURN TO WORK PROGRAM CLOSURE / EVALUATION REPORT – SUPERVISOR

Employee Name:	Department:
Occupation:	Supervisor Name:
Date of Injury/Disability:	Claim No. (WSIB, STD, LTD):
Plan Start Date:	Plan End Date:
Total No. of Lost Days (Prior to RTW Plan):	Total No. of Accommodated Days:

QUESTION	YES	NO	N/A
1. Were all accommodations in place prior to the employee's return to work? Comments:			
2. Did the employee experience any challenges or concerns with the RTW Plan? Comments:			
3. Were you able to resolve the employee's concerns with the RTW Plan in a timely manner? Comments:			

QUESTION	YES	NO	N/A
4. If you were unable to resolve the employee's concerns, did the RTWC resolve the employee's concerns with the RTW Plan in a timely manner? Comments			
5. In your opinion, were the employee's co-employees supportive of the employee's Return to Work Plan? Comments			
6. Was your overall experience with the RTW program positive? Comments			
7. Do you have any suggestions to improve the company's Return to Work program? Comments			

Thank you for providing valuable feedback on your experience with the Return to Work Program. Your feedback will be used to improve the company's Return to Work Program.

APPENDIX J- INCIDENT REPORT

INCIDENT REPORT FORM-EMPLOYEE

Reporting a(n)	Person Involved
☐ Incident ☐ Near Miss ☐ Health & Safety Concern	☐ Employee ☐ Volunteer ☐ Student ☐ Visitor ☐ Other (please specify)_____

SECTION A (Please print clearly and complete all required fields)	
Date/Time Reported	**Date/Time of Injury/Illness**
Name	**Position/Department**
Home Phone #	**Cell Phone #**
I hereby declare that the information I have provided on this form is true and accurate to the best of my knowledge.	**Signature**

SECTION B

Nature of Injury/ Illness

☐ Strain ☐ Fall ☐ Cut ☐ Harmful Substance ☐ Environmental ☐ Mental Health

☐ Sharps Injury/ Body Fluid Exposure ☐ No Injury ☐ Other (please specify) _____

Area of Injury (i.e. left wrist)

First Aid Provided ☐ Yes ☐ No	**If yes, by whom:**	**Describe First Aid Provided**
Location of Incident/Concern		**Name of Resident (if applicable)**

SECTION C Description of incident/concern: (Specify details including: location, date/time and environment)

SECTION D

When did you first notice the pain?	**Did you notify the Enter Designated Individual?**
☐ Sudden ☐ Gradual Onset	☐ Yes ☐ No

Date Reported	Time Reported
☐ Other (please specify) _____	If yes (full name/ position) _____
Are you aware of any witnesses? ☐ Yes ☐ No If yes (full name/ position) _____	**Where did the injured/ill person go after the incident?** ☐ Return to work ☐ Hospital ☐ Clinic ☐ Home ☐ Other (please specify) _____
DOCTOR'S PACKAGE: ☐ Taken ☐ Not Taken A doctor's package must be taken if outside medical aid is sought for a workplace injury/illness. Please be sure to notify the Enter Designated Individual at Ext. #Enter Extension #.	

PLEASE SUBMIT REPORT TO Enter Designated Individual IMMEDIATELY FOLLOWING COMPLETION

SECTION A – Root cause: Specify acts/ conditions/ job factors that contributed to the incident/ concern.

SECTIONS B – Preventions: What action(s) have or will be taken to prevent a re-occurrence?		
Employee's next schedule shift:		
Manager/Supervisor (Please print clearly)	**Signature**	**Date/Time**

FOLLOW-UP ACTION – The Department Manager must complete the section below.		
Department Manager (Please print clearly)	**Signature**	**Date/Time**

PLEASE SUBMIT COMPLETED REPORT TO Enter Designated Individual.. INCIDENT REPORTS & HEALTH AND SAFETY CONCERNS FORMS WILL BE REVIEWED AT JHSC MEETING.