RETURN TO WORK POLICY
210

I. PURPOSE

To establish uniform guidelines for providing employees with restricted duty while they are rehabilitating or recovering from an occupational or non-occupational illness or injury.

II. POLICY

Any employee who has been released to return to work, with restrictions, either from an occupational or non-occupational illness or injury, must present a written release from their attending physician that defines the extent of their restrictions.

Upon presenting the written return to work release, it will be reviewed by Management. Management will review the availability of restricted duty based upon the current needs of the company. This review of available work will be based upon assignments which the employee is qualified to perform. On a case by case basis, Management will determine the length and nature of restricted duty available.

In the event that the company determines that restricted work is available, the length of the restricted duty will be decided by Management. Each instance of approval or disapproval is subject to review.

In the event that the company does not have restricted duty available for the employee, the employee will not be permitted to return to work until they can perform their regular job duties in accordance with their scheduled work hours. In each instance, the company will determine the need for additional information, clarification or a supplemental examination by a company-designated physician.

For Occupational Illnesses or Injuries the attending physician shall complete the "Treatment Restriction Report". For Non-Occupational Illnesses or Injuries the attending physician shall complete the "Work Status" form.

TREATMENT / RESTRICTION REPORT
FOR
NON-WORK RELATED INJURY OR ILLNESS
210 A

GTC REQUIRES EMPLOYEES WHO HAVE BEEN ABSENT FROM WORK FOR MORE THAN 3 DAYS WITH A NON-OCCUPATIONAL INJURY OR ILLNESS TO HAVE INFORMATION REGARDING WORK STATUS ON FILE PRIOR TO RETURNING TO WORK. PLEASE HAVE YOUR TREATING PHYSICIAN COMPLETE THE INFORMATION BELOW. IT IS YOUR RESPONSIBILITY TO RETURN THE COMPLETED FORM TO YOUR SUPERVISOR/FOREMAN BEFORE BEGINNING YOUR NEXT SCHEDULED SHIFT.

Employee Name:_____ **Date:**_____

WORK STATUS: It is my opinion that this employee: (Please check one)

1) Can return to his/her **regular job:** (date) _____

2) Fully recovered with no restrictions: _____ yes _____ no

3) Can return to work with the following **restrictions:**

a) Employee **can work:**_____ **hrs/day** _____ **days/week**

b) **Lifting:**_____10 lbs. _____ 20 lbs. _____ 30 lbs. _____50 lbs. _____ No restriction

c) In an 8-hour work day, employee can **stand/walk:**
_____None _____1-4 hrs. _____4-6 hrs. _____6-8 hrs. _____ No restriction

d) In an 8-hour work day, employee can **sit:**
_____None _____1-4 hrs. _____4-6 hrs. _____6-8 hrs. _____ No restriction

e) Employee is able to:	Not at all (1 – 33 %)	Occasionally (34 – 66%)	Frequently (67 – 100%)	No restriction
Bend	_____	_____	_____	_____
Squat	_____	_____	_____	_____
Twist	_____	_____	_____	_____
Climb	_____	_____	_____	_____
Push/Pull (____lbs)	_____	_____	_____	_____
Reach over head	_____	_____	_____	_____

f) Other:_____
Restrictions in effect until (date):_____

3) Is the employee on any medication that would cause drowsiness, decrease his/her ability to concentrate or otherwise pose a potential safety concern with its use on the job?

_____ No _____ Yes: Please list name of med(s)_____

Physician's Signature:_____ Date:_____

TREATMENT/RESTRICTION REPORT
210 B

TO:_____
(Medical Facility, Attending Physician, Health Care Provider)

Kindly render treatment necessary to the employee named below, subject to provisions of the Workers' Compensation Act

Employee Name: _____

Date of Injury : _____ Authorized By: _____

Today's Date: _____ Time In: _____ Time Out: _____

Nature of Injury/Illness: _____

Treatment: _____

Whenever possible without compromising the level of patient care, please use an over-the-counter medication. OTC meds are paid by GTC Workers' Compensation.

If any, what medication was recommended? _____

Was this a prescription medication? ____ no ____ yes

Was an X-ray taken: ____ no ____ yes

Will follow-up care be required? ____ no ____ yes

If yes, please list next appointment _____ _____
(Date) (Time)

If employee is referred to another physician, please indicate to whom:
_____

Please complete the "Work Status" portion of this Treatment / Restriction report located on the reverse side of this form. If an employee has been accompanied by medical or supervisory personnel from GTC, a review of the employee's status following your exam would be greatly appreciated.

Employee Name: _____ Date: _____

WORK STATUS It is my opinion that this employee: (Please check one)

l) ___ Can return to his/her regular job ___ immediately ___ next scheduled shift
___ on (give approximate date) _____

2) ___ Is unable to do any type of work and is temporarily disabled until approximately:
_____

3) ___ Can return to work with the following restrictions:

A) Employee can work: _____hrs/day _____days/week __ No restriction

B) Lifting: ___ l0 lbs. ___ 20 lbs. ___ 30 lbs. ___50 lbs __ No restriction

C) In an 8 hour work day, employee can stand/walk:
___ None ___ 1-4hrs ___ 4-6hrs ___ 6-8hrs __ No restriction

D) In an 8 hour work day, employee can sit:
___ None ___ 1-4 hrs ___ 4-6 hrs ___ 6-8 hours __ No restriction

E) Employee is able to:

	Not at All (1 - 33%)	Occasionally (34 - 66%)	Frequently (67 - 100%)	No restriction
Bend	___	___	___	___
Squat	___	___	___	___
Twist	___	___	___	___
Climb	___	___	___	___
Push/Pull (___lbs)	___	___	___	___
Reach over head	___	___	___	___

F) Other: _____

Restrictions in effect until (date): _____/_____/_____

G) Fully recovered: _____ yes ___ no _____

_____ _____
(Physician's Signature) (Date)

Authorization for Release of Medical Information

I, _____, authorize the release of all medical records and the
(Employee's Signature)
results of diagnostic studies pursuant to this medical examination on _____
to GTC; and/or other appropriate officials and insurance carriers.