**Appendix 8.0 – Return to Work**

**Please Read The Following Before Completing The Attached Form**

Dear Doctor:

Please complete the ***Health Professional’s portion*** of the attached Functional Abilities Form indicating the employees’ readiness to return to work. At Danosh Construction Inc. we are committed to working with you and our employees to help him/her return to work in a suitable position.

Should light/modified duties (i.e. restricted lifting, bending, standing) be required, we will develop a work program specifically designed to accommodate your patient’s limitations (i.e. restricted lifting /bending assignments, sit/stand duties) until he/she is able to return to his/her regular duties.

According to the Workplace Safety and Insurance Board’s Bill 99, Section 40 (1) (2), the employer and the worker must cooperate in the employee’s safe and early return to work. If you have any questions regarding our Return to Work Program, please contact the Manager Safety and Human Resources at (905) 473-6883.

Thank you for your treatment of our employee and your attention to this request.

Sincerely,

Frank Kelly, Owner

Danosh Construction Inc.

**Medical Waiver Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ was injured at work on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(EMPLOYEE NAME) (DATE)

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please choose **one** of the following:

[ ]  I sought medical attention on the following day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at the following hospital or clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as a result of my workplace injury.

**OR**

[ ]  I did not seek medical attention as a result of my workplace injury. However, I agree to inform the Safety and Human Resources Manager, if I do seek medical attention within the next fourteen (14) days of my work related injury.

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

(EMPLOYEE SIGNATURE) (NAME)

THIS FORM MUST BE GIVEN TO THE WORKER AT TIME OF INJURY AND PROMPTLY RETURNED TO THE MANAGER SAFETY AND HUMAN RESOURCES UPON COMPLETION.

**Return to Work Contact Log**

|  |  |
| --- | --- |
| Part One – Record of Contact **Employee’s Name:**  | **Phone #:**  |
| **Supervisor:**  | **Phone#:**  |
| **RTW Date:**  | **Review Date:** **Target End Date:**  |
| **Treating Physician(s):**  | **Phone #(s):**  |
| **WSIB Claim Number** **WSIB Claims Adjudicator:**  | **Phone #:****Fax #:** |

It is the supervisor’s responsibility to ensure this form is kept up-to-date and in the Claims Management file established for the injured worker.

**Record of Contact**

|  |  |  |
| --- | --- | --- |
| **Date of Contact**  | **Person Contacted**  | **Contents of Conversation**  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Part Two – Modified Duties

If modified duties are required then the supervisor, in conversation with the Manager, Safety and Human Resources, injured worker and appropriate care providers must complete the following

Description of Employees Job:

**(Attach Physical Demands Report for Employees Job)**

Transitional Work Plan (if required)

Pre-Injury Job: Other suitable work required: **Yes** 􀀀 **No** 􀀀

If yes, what is the other suitable work:

Pre-Injury Job with Accommodations, specify

Other suitable work, with accommodations:

(wages, hours, rotation, minimum’s/maximum’s)

Medical Precautions (Attach Functional Abilities Report, if applicable)

Injury / Incident Corrective Action Form

Date if Injury / Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injury / Incident number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Corrective Action Taken** (as indicated on the Accident / Investigation Form):

|  |
| --- |
| **Recommendations**  |
| **Date assigned**  |
| **Responsibility assigned to:**  |
| **Details of What is to be done**  |
| **Who has completed it**  |
| **When it was completed**  |