FRESNO COUNTY
SELF INSURANCE GROUP

March 17, 2010

MEMORANDUM FOR: **JPA Liaisons**
JPA Safety Officers
JPA Contact People

SUBJECT: **Return to Work Plan Improvement**

Bill Tucker, Broker/Administrator; Sharon Castillo, Third Party Administrator (TPA); and I have recently been reviewing the JPA's "Return to Work" strategies. Aggressive efforts are made by Sharon and her staff at Tristar to return injured or ill employees to work as soon as possible. The districts can also utilize the suggestions contained in the *Return to Work* program distributed to districts earlier. In addition, the "Nurse Early Intervention Program" is helping to return employees to work as early as possible.

One additional step that has not been undertaken is to make available to each district a physical requirement form to be attached to each job description and a corresponding physician's response form. A firm that specializes in this type of work, Vocational Horizons, Inc., owned by Alexis Zerga, M.S., C.R.C., was asked to draft both forms: 1. ***Description of Physical Requirements***, and 2. ***Physician's Response***. Utilization of these forms will provide the doctor detailed information needed to assist the physician when making a return to work decision. Please consider incorporating the ***Description of Physical Requirements*** into all of your job descriptions and provide the treating physician with the ***Physician's Response*** form. Incorporating these forms in your return to work program may likely save on the claim costs because the physician and TPA will have additional information on which to base decisions. These two documents are in the PDF attachment associated with this correspondence.

If you have any questions please contact me.

Henry Brock
Risk Manager

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INSTRUCTIONS FOR COMPLETING PHYSICAL REQUIREMENT FORM

READ THIS FIRST! This form describes the physical requirements necessary to complete the job described on the corresponding job description. This is an important document. The completed form will be reviewed by the physician authorized to treat an employee who is losing time from work due to injury or illness. The physician will use this information to determine whether the employee is able to return to work, return to transitional (light duty) work with restrictions, or has sustained permanent restrictions which are likely to preclude a return to work without accommodation. It is very important that the completed form accurately describe the physical requirements of the job. To complete the form, use black ink and print clearly.

1. **JOB TITLE:** Print job title as it appears on the corresponding job description. Do not use abbreviations or acronyms.

2. **HOURS:** Indicate hours worked each day and total hours worked per week. If the employee is required to occasionally work overtime, works a split shift, works a rotational shift or is occasionally required to work on weekends or holidays, indicate this information under the Comment Section on Page 2.

3. **DEPARTMENT:** Print the Department to which this job is assigned (i.e., Dept. of Maintenance and Transportation). Do not use abbreviations or acronyms.

4. **ACTIVITY:** For each physical activity listed, check the box that most accurately describes the frequency with which the activity is performed throughout an average workday. Use the definitions that appear at the top of the form. As a general rule, the total time spent sitting, standing and/or walking cannot exceed 100% of the day. If the activity is best described by the "Other" category, indicate the specified time period if the activity is performed rarely or infrequently (i.e., Rare/wk). Include example(s) of each activity (i.e., under Climbing examples could include ladders, stairs, scaffold, etc.). If the job requires the employee to perform certain duties that are not typically required in an average work day (i.e., deep cleaning required by custodians during school breaks), indicate these duties under the Comment Section on Page 2; include the frequency and lifting/carrying demands of these unique aspects of the job.

5. **LIFTING/CARRYING REQUIREMENTS: Lifting:** For each weight range, check the box that most accurately reflects the weight lifted and the height from which the object is lifted. Include example(s) for each weight range (i.e., under the 0-10 lbs range examples could include hand tools, cooking utensils, office supplies, etc.). Avoid guessing the weights of objects by weighing items or by checking weights that appear on shipping boxes, manufacturer's specifications, etc. Weights of objects are often disputed by employees and are often used by physicians in assigning specific work restrictions. **Carrying:** For each weight range, check the box that most accurately reflects the weight carried and the

distance the object is carried. Include example(s) if different than those listed under the Lifting category. Avoid guessing distances; use a tape measurement whenever possible. Indicate by name the heaviest object carried, the object's weight and the distance the object is carried.

6. **WORK ENVIRONMENT:** For each category, check if the employee is required to perform the activity. If yes, provide example(s); (i.e., for Walking or Balancing examples could include roofs, bus bumpers, school yards/playing fields, etc.).

7. **COMMENTS:** Use this section to clarify information on the form or to provide information you believe is important and that will assist the physician in making a determination regarding return-to-work status.

8. **SIGN THE COMPLETED FORM.** Include your title, your telephone number and the date on which the form was completed.

Thank you for taking the time necessary to complete the form. The completed form should be returned to:

Name: _____ Title: _____

Department: _____ Phone: _____ Fax: _____

E-Mail: _____

DESCRIPTION OF PHYSICAL REQUIREMENTS

This form describes the physical activities, the frequency of each activity and examples of activities required to perform the job outlined in the preceding job description. Definitions used to complete the form are:

Occasional	Up to 3 hours or 33% of an average workday
Frequent	3 to 6 hours, or 34-66% of an average workday
Constant	6+ hours, or 67-100% of an average workday
Other	*Used when the activity is best described as:*
	N/A Never, or not required in the position
	Rare 5 minutes or less per specified time period
	Infreq Infrequent, or 6 to 30 minutes per specified time period
	Intermit Intermittent; activity is performed on a stop/start basis at periodic intervals.

JOB TITLE:	HRS/DAY	HRS/WEEK

DEPARTMENT:

GENERAL JOB DESCRIPTION/REPRESENTATIVE DUTIES: Refer to Attached Job Description

ACTIVITY	OCC.	FREQUENT	CONSTANT	OTHER	EXAMPLES
Sitting					
Walking					
Standing					
Bending (Neck)					
Bending (Waist)					
Squatting					
Climbing					
Kneeling					
Crawling					
Twisting (Neck)					
Twisting (Waist)					
Hand Use: Dominant: R/L					
Repetitive: Y/N					
Simple Grasp (R)					
Simple Grasp (L)					
Power Grasp (R)					
Power Grasp (L)					
Fine Fingering (R)					
Fine Fingering (L)					
Push/Pull (Right)					
Push/Pull (Left)					
Reaching: Above Shoulder					
At Shoulder to Waist					
Below Waist					

JOB TITLE:
Page Two

HEIGHT:	F – From the floor	T - Table height	O - Overhead

ACTIVITY	OCC.	FREQUENT	CONSTANT	OTHER	HEIGHT	EXAMPLES
Lifting 0-10 lbs						
11-25 lbs						
26-50 lbs						
51-75 lbs						
76-100 lbs						
100+ lbs						
Carrying 0-10 lbs					DISTANCE	
11-25 lbs						
26-50 lbs						
51-75 lbs						
76-100 lbs						
100+ lbs						
Heaviest item carried: _____ **Weight:** _____ **Distance:** _____						

WORK ENVIRONMENT	YES	NO	DESCRIPTION:
Driving cars, trucks, forklifts or other equipment			
Working around equipment or machinery			
Walking and/or balancing on uneven surfaces			
Exposure to excessive noise			
Exposure to extreme temperature/humidity/wetness			
Exposure to dust, gas, fumes, chemicals			
Working at heights			
Operation of foot controls or repetitive foot motion			
Use of special visual or auditory protective gear			
Working with or exposure to bio-hazards (i.e., blood born pathogens, sewage, hospital waste)			

Comments:

This form was completed by:

Name: _____ Title: _____ Phone: _____ Date: _____

PHYSICIAN RESPONSE

To: _____
_____
_____

From: _____
Telephone: ( )_____
Fax: ( )_____

Dear Doctor: You are the physician authorized to treat the below-named employee who is currently losing time from work due to injury or illness. Our goal is to provide transitional work to our employees whenever possible. Following your review of the job description and physical requirement form, please complete this response form and fax this form within five days to the case manager listed above. Thank you for promptly responding to this request. Should you have any questions or require additional information, please do not hesitate to call the case manager.

Employee Name: _____ Social Security: _____ Birth Date: _____

Employer: _____

Work Site/Address: _____

Based on my examination completed on _____and the job description information submitted, it is my opinion this employee:

- ☐ **Can return to regular work duties without restrictions**
- ☐ **Can work:** 4 6 8 hours per shift. (Circle one)
- ☐ **Can return to work with the following restrictions:**

  Cannot (Check all that apply)
  - ☐ Lift/push/pull/carry more than 10 20 30 40 50 lbs frequently or repetitively.
  - ☐ Lift/push/pull/carry more than 10 20 30 40 50 lbs at any time.
  - ☐ Bend or stoop more than ____ hours.
  - ☐ Walk or stand more than ____ hours.
  - ☐ Repetitively climb, kneel or squat more than ____ hours.
  - ☐ Climb ladders or work at heights more than ____ hours.
  - ☐ Operate vehicles or moving equipment more than ____ hours.
  - ☐ Sit more than ____ hours.
  - ☐ Limited use of: R hand/leg L hand/leg

Employee should be provided work that allows:

- ☐ Opportunity to sit/stand ____ minutes each hour.
- ☐ Working at a rate that is tolerable, considering the injury.
- ☐ Limited use of R arm/hand L arm/hand R leg/foot L leg/foot.
- ☐ Sitting only.
- ☐ Icing/elevation of the injured extremity for:____
- ☐ Keeping injured area clean/dry.
- ☐ Continue current restrictions as previously documented.
- ☐ Other: _____

(Circle One)
Patient is: Improved Unchanged Worse

Work status changed: Yes No
If yes, explain: _____
_____.

Modified work restrictions changed: Yes No
If yes, explain: _____
_____.

Additional Restrictions or Comments:

- ☐ **Cannot return to any work from::** _____ **to:**_____.
- ☐ **Follow up appointment on:**

_____ _____
Physician Name Phone Number

_____ _____
Physician Signature Date