Creating a Stay-at-Work Program

A Key Element in Reducing the Cost of Workers' Compensation

MEMIC

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Reproducible Forms and Documents can be found at www.memic.com
by clicking on the link to **MEMIC's Safety Director.**

Learning Objectives

Creating a Stay-at-Work Program

At the end of this training session, you will be able to:

1. List the benefits of a Stay-at-Work Program.

2. Identify the steps needed to create a Stay-at-Work Program.

3. Describe the importance of the Preferred Provider relationship.

4. Outline the steps of your company's reporting and tracking process.

5. Fill out Sample Transitional Duty Job Descriptions.

Introduction

A Stay-at-Work Program is designed to either keep injured workers at work or return them to the workplace as soon as possible and performing meaningful, productive work within the limits of their physical capabilities/restrictions while they transition back to their full-time position. This, in turn, reduces the effects of the injury on the injured employee and the workplace.

It has been known for some time that injured workers experience both physiological and psychological symptoms when they are suddenly removed from a productive, active environment to assume a more passive role. Providing transitional duty can minimize some of those adverse effects.

A comprehensive Stay-at-Work Program has been identified not only as one of the key elements necessary to contain and reduce the cost of workers' compensation, but also as being beneficial for both the employer and the employees. To be successful, a program must contain the following components:

- Company commitment to workplace safety
- A process to manage injuries and injured workers
- Provision of transitional work
- Effective communication between the employer, the employee, and the medical provider

Stay-at-Work Program

A Stay-at-Work Program is designed to:

- Promote immediate reporting of injuries to management
- Keep the injured employee in the workplace (aside from doctor's appointments)
- Provide meaningful, productive work within the limits of temporary physical restrictions
- Enhance recovery and return to permanent full-work capacity as soon as possible
- Be temporary/time limited, with the ultimate goal of returning injured workers to their prior positions

Note: Synonymous terms for Stay at Work are light duty, modified duty, return to work, temporary alternative duty, and transitional duty.

Stay-at-Work Questionnaire:

What Policies and Procedures Do You Already Have?

Please check "Yes" or "No" and provide additional information as necessary for each of the following questions.

Yes	No	Stay-at-Work Questions
❍	❍	Do you have a system for tracking injured workers to monitor their status? If so, what?
❍	❍	Do you have a person (or persons) trained to provide quality support, guidance, and information on the workers' compensation system to the injured worker (and to management)?
❍	❍	Do you provide job descriptions with the physical requirements of the job to the treating physician?
❍	❍	Have you identified and developed a relationship with an established, highly qualified health-care provider in your area?
❍	❍	Do you promote its services as a benefit to employees?
❍	❍	Do you treat injured workers with dignity and respect? How?
❍	❍	Do you establish joint responsibility with injured workers for recovery? If so, how?
❍	❍	Do you avoid lost time and "entry" into the workers' compensation "system" by having a flexible transitional work program?
❍	❍	Do you involve immediate supervisors in your workers' compensation management program? How?
❍	❍	Do you provide appropriate transitional work assignments?
❍	❍	Do you communicate with physicians, adjusters, injured workers, and others as appropriate regarding the medical management process?
❍	❍	Do you utilize physical conditioning and work-hardening programs? How?

The advantages of having a Stay-at-Work Program are:

1. **Decreased Recovery Time:** Current sports medicine treatment advocates muscle use and physical activity to hasten the healing process. Keeping employees at work provides that activity while maintaining work capacity.

2. **Physical Conditioning or Work Hardening:** Physical and mental activity is necessary for the recovery of the injured employee. The act of going to work and performing some functions helps maintain physical and mental conditioning. Lack of activity contributes to the severity of the injury and increases the time for recovery.

3. **Maintenance of the Work Ethic/Positive Attitude:** The injured employee who continues (or returns to) a daily schedule of going to work has less tendency to develop those habits which might weaken his or her work ethic and inhibit the return to work after physical recovery and also has a better chance of sustaining a positive attitude.

4. **Expenses/Cost Control:**

    a. Economic burden occurs for both the employee and the employer. For the employee, although compensation is sometimes close to take-home pay, it is not a total replacement. This difference creates a financial burden on the worker, one that would be lightened if he or she remained in or returned to the workplace. (Each state has different laws which govern the amount of weekly wage reimbursement for the injured employee.)

    b. The savings for the employer come in the form of reduced lost time. Payment of weekly workers' compensation benefits, wages for a replacement person, training costs, and loss of productivity all cause an increase in operating costs.

The benefits can be stated in a nutshell.

1. **Benefits to employer:**

- Reduces indemnity dollars from lost time wages, thus impacting favorably on the experience modification (mod) factor.
- Maintains production for wages paid.
- Avoids the cost of training and hiring replacement employees.
- Facilitates contact between employer and employee, giving the employer control, direction, and positive resolution of the claim.
- Reduces the number of fraudulent claims.
- Promotes better morale among all workers.

2. **Benefits to employee:**

- Increases self-esteem.
- Contributes to faster recovery by keeping the injured worker from becoming physically deconditioned to a regular work schedule.
- Maintains social contact with fellow employees.
- Reduces negative financial impact.

3. **Win-win situation for both employer and employee:**

- The employer wins by retaining the use of valuable trained employees while minimizing workers' compensation costs.
- The employee wins by returning to his/her place of work and avoiding the negative effects of a long-term absence.

Cost Analysis

The following is an example of a cost analysis detailing the costs of failing to provide a Stay-at-Work Program.

An employee has sustained a soft tissue injury and has obtained a work release with restrictions, but the employer does not have a meaningful Stay-at-Work Program in place. The employee remains out of work for a period of six months.

- Employee's gross average weekly wage: $300
- Weekly workers' compensation payments (60% of $300 for 26 weeks) $4,680
  - 60% is the average weekly wage (A.W.W.) for New Hampshire*
- Medical costs during six months $2,000

A replacement was needed while the employee was out of work:

- ***Replacement's weekly wage for 26 weeks: $300***
  - For 26 weeks $7,800
- Training costs incurred, production losses, etc. $5,000

TOTAL COSTS $19,480

Cost if employer had 10 similar cases $194,800

* Compensation benefits will vary according to state law; in Maine it is 80%, in Vermont, 66-2/3%.

- **Put It in Writing:**
  - Your Stay-at-Work policy and procedures must be written to ensure consistency, accountability, and direction.
  - A policy statement does not need to be elaborate, though it should express management's commitment to ensuring a safe and injury-free workplace, access to prompt medical treatment, and provision of Stay at Work.

- **Define Roles and Responsibilities:**
  - Written procedures should clearly define the reporting process and the roles and responsibilities of all involved parties throughout the course of the injury management process.

POINTS TO PONDER:

Management Attitudes that Cause Potential Barriers

1. The worker must be able to perform his/her former job in full before being returned to work.
2. Out of work is cheaper and easier than dealing with the underlying employment issues.
3. The risk of reinjury is greater if the employee is returned too soon.
4. The employer has no say in how the health provider system treats company employees.

- **Keep Employees Informed and Trained:**
  - Employees must be instructed on how to report any and all work-related injuries/incidents to their supervisors immediately. Incidents include any event in which an employee is injured, even if no medical treatment is provided.

- **Build Relationships:**
  - Establish a relationship with a medical provider who will offer immediate medical treatment, if necessary.
  - The designated workers' compensation contact will file a report with MEMIC (or MEMIC Indemnity Co.) and will communicate with the treating physician, the injured employee, and the supervisor to coordinate Stay at Work and to provide support and direction throughout the injury process.

- **Develop a Notification Process:**
  - A formal notification of the incident should be immediately reported to the designated workers' compensation contact, along with completion of your state's First Report of Injury.
  - (It has been shown that injuries reported within the first 24 hours can reduce the total costs of a claim by 50% or more, when compared with cases reported 5 days following an injury.)

A Stay-at-Work Program should include systems and policies which support a formal injury- or incident-reporting process, provide for medical treatment, and outline specific responsibilities for the employee, the supervisor, and the designated workers' comp contact. To lay the groundwork, write a clause into your company's safety policy statement that acknowledges the importance of accident investigation and injury management. For an example of a Safety Policy Statement as well as a Sample Injury Reporting Procedures document, see Appendix A. (Note: A "clean" set of most of the sample forms and documents mentioned in this manual suitable for photocopying, is inserted in the inside back cover pocket.)

The following steps will serve as a guideline for establishing a comprehensive Stay-at-Work Program in your company:

1. Establish formal, written Stay-at-Work policies and procedures.
2. Notify, inform, and train all employees. Provide for refresher training to reinforce understanding.
3. Set time-limited reporting requirements.
4. Clearly define roles and responsibilities of injured worker, supervisor, and designated workers' comp contact.
5. Identify name and location of established medical providers.
6. Establish a mandatory process for communication between employer, injured worker, and medical provider.
7. Clarify any company-specific policies related to the workers' compensation benefit process, such as
   - Pay rates for transitional work
   - Time limits of the transitional work assignment
   - Creation of job bank or transitional work positions
   - Attendance at and transportation to medical appointments
   - Communication expectations from health-care provider
   - Refusal of work
   - FMLA (Family Medical Leave Act)
8. Establish a schedule for program/policy review at least annually.

POINTS TO PONDER

The most effective Stay-at-Work Program must be in place before it is needed!

Don't wait until you need it to create your program.

Relationship with Medical Provider

Choosing and establishing a relationship with a medical provider to act as medical gatekeeper for treatment of injured employees will provide benefits to both the employer and the injured worker.

The goal is to establish a system for facilitating immediate access to treatment, for provision of appropriate medical care and progressive physical restrictions, and for assuring a smooth return to work through accommodation of restrictions during the recovery process.

POINTS TO PONDER

Most doctors have a limited understanding of what a Stay-at-Work Program is.

It is the employer's responsibility to set the standards for Stay at Work and communication with the health provider.

Steps to Establishing a Relationship with Your Medical Provider:

Meet with the provider:

- Set up a meeting, give a guided tour, provide lunch, make the medical provider familiar with your facility.
- Have an employer representative meet with the medical provider to review the company's Return to Work/Stay-at-Work Program, clarifying your philosophy on provision of alternate duty.
- Encourage the medical provider to visit your company and observe specific job tasks and requirements, for a better understanding of your return-to-work philosophy.
- Keep in mind that open communication between the employer and the medical provider is essential.

Create expectations for communication:

- Establish a process for the medical provider to communicate directly with the employer immediately following the treatment of all injured employees and afterwards, if follow-up care is necessary. The process should include accurate completion of your state's Workers' Compensation Medical Form and establish the method of communicating (fax, phone, e-mail) the injured employee's status.
- Designate contact persons at both the company's and provider's offices to assure timely clarification and communication.

Plan alternative jobs:

- Identify jobs/tasks to accommodate restricted duty ahead of time.
- Provide the medical providers with job descriptions and job task analyses for both permanent and transitional duty positions.
- Review with the doctor your company's willingness to adjust current job descriptions in compliance with the restrictions imposed by the doctor on a case-by-case basis.

Potential Health-Care Provider Challenges

1. Lack of consistency/continuity in medical providers
2. Delayed access to occupational care or specialist care
3. Ineffective or unproven therapies
4. Failure to understand the context of the injury
5. Failure to fully grasp the scope of the employer's line of work
6. Confusion between subjective complaints and objective findings
7. Acute care vs. chronic care
8. Failure to communicate with the patient and others involved
9. Failure to utilize progressive-return or transitional work
10. Failure to consider return to work as an end point
11. Adversarial relations with employee
12. Failure to discriminate between the pain and the disability

It can sometimes be difficult to identify transitional duty positions within a company. However, by analyzing jobs and by involving individuals at all levels of the organization, from managers to supervisors to employees, in the process, a significant number of meaningful and productive transitional duty positions are likely to be identified.

There are two paths to transitional duty. The first one involves the identification, ahead of time and before any specific injury has occurred, of jobs or tasks within your company that can accommodate restricted duty. The second one is more case-specific and involves making adjustments in the requirements of a particular job when restrictions are given for an individual injured employee.

1. **Developing a transitional job pool:**
    a. Make a pre-injury determination of those jobs or tasks that can accommodate transitional duty.
    b. Analyze each job/permanent position within the company for its essential functions, physical demands, and hazards using a Job Task Analysis Form, which should be jointly completed by supervisors and employees.
    c. Compare the positions and essential functions with the historical restrictions that have been provided by your medical provider.

2. **Adjusting job requirements when restrictions are given:**
    a. Follow this progression:
        i. Return to Same Position, Same Duties, Same Department
        ii. Return to Same Position, Different Duties, Same Department
        iii. Return to New Position, Different Duties, Same Department
        iv. Return to New Position, Different Duties, New Department

Regardless of which path you choose, involve all employees in the process of suggesting jobs/positions which may be appropriate for temporary alternative duty. The Joint Loss Management Committee/Safety Committee, together with department supervisors and other employees, should help develop job task analyses for each of the transitional duty positions identified.

A sample Job Analysis may be found in Appendix A. This form, or one like it, can be used to identify the essential and peripheral physical requirement of a job. It can also be helpful in creating your transitional job pool or, in conjunction with your medical provider, in modifying a job or task so that it accommodates restrictions.

A useful tool for defining the physical capacity of injured employees is the Physical Assessment Evaluation form, which also may be found in Appendix A. Used in conjunction with your state's Workers' Compensation forms, it provides further essential information to your medical provider for determining restrictions. It should be reviewed with your medical provider when outlining what you expect from the provider in terms of communication and Stay at Work (see Sample Letter to Physician/Medical Provider in Appendix A).

POINTS TO PONDER

Don't forget to communicate with your preferred provider about how the transitional work process works at your company.

From the ***employer*** standpoint:

- Transitional duty must be meaningful work. Having an injured worker come to work and watch television during his or her shift as a way of avoiding lost time is *not* meaningful work.
- Meaningful work provides the employer with productivity (granted it may not be at the same level as a non-injured employee, but it is the beginning of a return to full productivity).
- Meaningful work increases the likelihood that other employees will accept and comply with the program after seeing how it works in action, which will lessen any lingering anger and frustration.
- Middle managers are the key players in making Stay-at-Work Programs a success. Those managers who demonstrate sincerity in their willingness to accommodate the injured employee through shifting jobs, modified work, limited hours, and physical conditioning will see the benefit of better morale and retention among all employees.

POINTS TO PONDER

Middle management can make or break your Stay-at-Work Program.

Don't assume that your managers understand how to make the program work.

Explain the program, and educate them in the mechanics of the program, what its benefits are, and the role management plays in the program.

From the ***employee*** standpoint:

- Meaningful work provides the injured workers with a sense of accomplishment, maintains their self-esteem, and decreases their feelings of guilt.

POINTS TO PONDER

Your employees should see the Stay-at-Work Program as a benefit.

Don't hide it until it needs to be used.
Make it a part of the employee training and revisit it often.

If you want the program to work, teach your staff how it will benefit them.

Points to Remember About Your Stay-at-Work Program and Transitional Duty

Copies of all transitional duty positions (as identified by job task analyses) should be kept on file by the supervisors and designated contact person at your company. The latter will make sure that all concerned parties (supervisors, employees, and providers) are kept informed about, updated on, and/or trained in the Stay-at-Work Program.

Transitional duty offers should be in writing, be sent by certified mail to the injured worker, and must include: acknowledgment of the medical provider's restricted assignment; job description; date/time job to begin; working hours and location; and wages to be paid for that job (see Transitional Duty Offer in Appendix A).

Transitional duty positions are temporary and may be restructured, expanded or otherwise amended at any time.

Transitional duty positions may need to be modified or clustered for individual employees in order to accommodate their specific physical limitations.

The bottom line is to remain flexible in your accommodation of an injured employee's restrictions. However, do not compromise the process. Always be clear regarding job duties, time limits, and the responsibilities of the employee, medical provider, and employer (see the Transitional Duty Agreement in Appendix A).

For an example of a Transitional Duty Position form, see Appendix A. It can be used by the employer to obtain the physician's approval for a transitional/modified duty position before offering it to the injured employee. This form can also serve to alleviate confusion in the injured employee's mind about what the physical expectations of his or her job entail and to provide a guideline which the Preferred Provider can adhere to when evaluating the progress of the injured employee.

Your company's commitment to providing transitional work/modified duty can be stated in a form letter that informs the Preferred Provider/medical provider about your expectations. For a Sample Letter to Physician/Medical Provider, see Appendix A.

Pre-Authorization for Visit to Preferred Provider

One way to make the encounter between injured employee and medical provider easier is to develop a system in which the initial visit is made to a company-approved provider. Under such a system, the need for the medical provider to contact the employer before assuming care of the injured worker is eliminated, thus speeding up treatment and starting the heath-care experience off on the right foot for the injured employee. Having a Preferred Provider also sets the expectation and increases the chances that the employee will notify the employer immediately when an injury occurs, knowing that the employer will provide access to medical care.

Such a system, furthermore, eliminates the problem of injured employees seeking medical care without the employer's being aware of the injury.

To be successful, this system must contain certain elements:

1. Written procedures for injury reporting.

2. A dedicated Preferred Care Provider (PCP).

3. A designated safety/claims contact at your company.

4. Agreement between the PCP and your company about what determines visit authorization. Note: This agreement does not signify acceptance of the entire claim, only that the employer acknowledges the injury and the need for care at the time of the visit.

5. Agreement between the PCP and your company that the former will notify the designated contact at your company if an employee shows up without the pre-authorization or outside a pre-scheduled appointment.

6. Reiterated instructions to your employees on:
    a. Reporting and authorization procedures, and
    b. The benefits of a system such as this, which are
        i. increased access to good providers,
        ii. targeted care, and
        iii. decreased time away from work.

7. Annual (or more frequently, depending on process and response) review of the system with the Preferred Care Provider.

How to Inform and Prepare Employees

Before you implement your Stay-at-Work Program, hold a companywide training session to set forth its policies and procedures. Provide copies of the written Return-to-Work/Temporary Alternative Duty Program, including roles and responsibilities of the employer, employees, and medical provider.

Include the following details in the training sessions:

- The benefits of the program for both the employees and the employer
- The expectations involved when pursuing a claim for workers' compensation benefits
- The effective date of the program
- The fact that transitional duty will be progressive, temporary, and subject to change at any time
- The provision of a health-care provider is a benefit for the injured worker
- The name and location of the designated health-care providers
- The designated contact persons both at your company and at the health-care provider's
- The specific procedures established for reporting all workplace injuries and illnesses

As part of the training process:

- Review the job task analyses that have been completed for existing permanent jobs and the transitional duty positions that have been formulated.
- Enlist employee participation in identifying and reporting other functions that may be incorporated into the transitional duty positions.
- Make clear to employees your commitment to the program and your sincere desire to make it work.

Once hired, all new employees should be given copies of the Return-to-Work/Temporary Alternative Duty policies and procedures, including the list of available transitional duty positions.

POINTS TO PONDER

Don't assume that everyone who attended the meeting now understands, or even buys into, the program. Provide multiple opportunities to reeducate and sell the employees and managers on the program--how it works and its benefits (to them).

Conclusion

Creating a Stay-at-Work Program is not only cost-effective but also employee-friendly. This manual sets a goal and projects hoped-for outcomes when your company has to deal with workers' compensation claims and injured employees.

Goal:

- To develop a systemic approach to managing work-related injuries, one that provides benefits to both employee and employer.

Outcomes:

- Reduction in workers' compensation costs by decreasing lost time and enhancing return to work.

- Improved employee relations due to an empathetic, rather than adversarial, approach to work-related injuries.

This manual will not solve all the problems associated with returning injured workers to the workplace. But when injuries do occur, having your Stay-at-Work Program in place (and ensuring that it is well understood by all employees and designated medical providers) will ease the process and help keep the workforce happier and more productive.

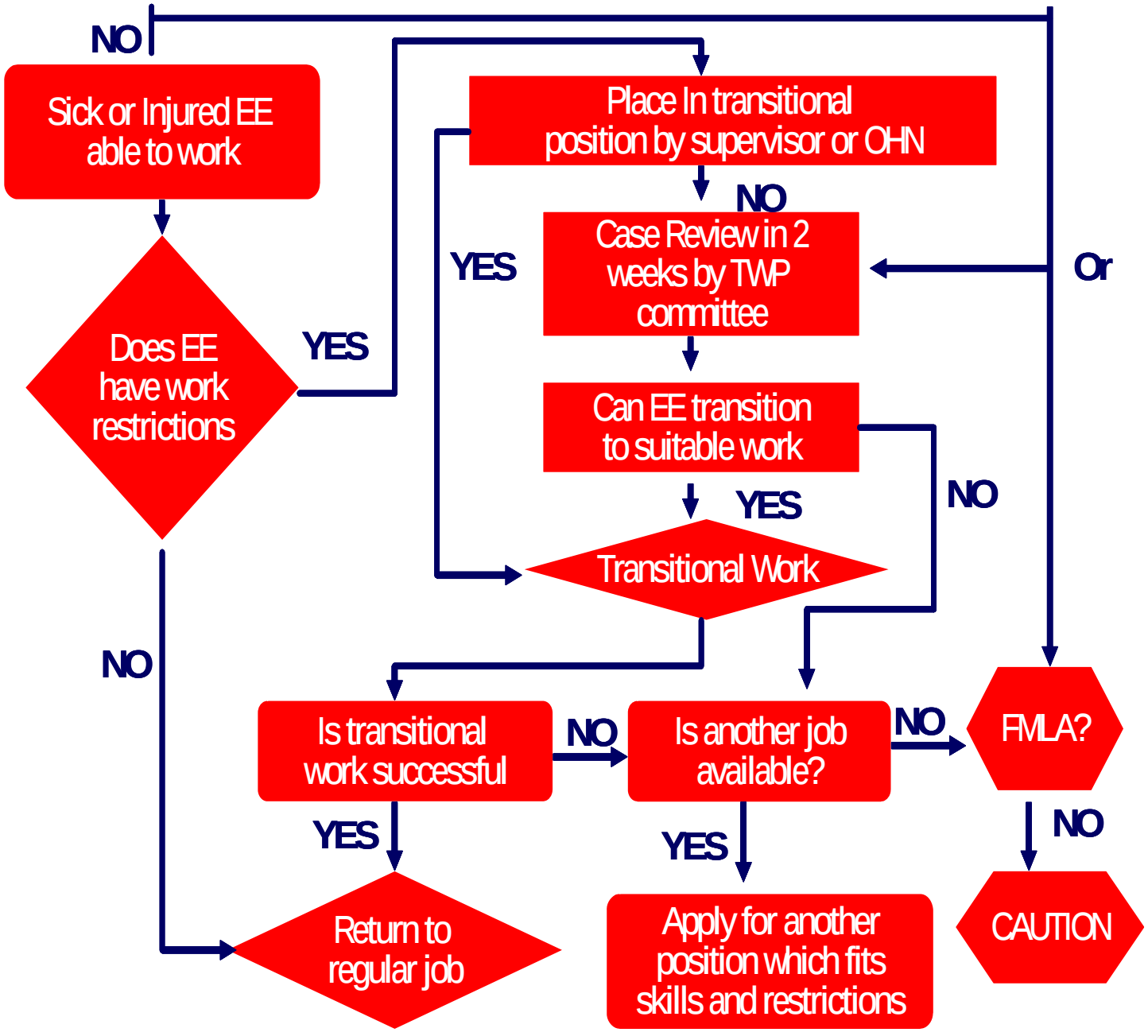
Appendix A

The following pages contain sample forms and documents that are integral to an effective Stay-at-Work Program. Perhaps the most crucial form is the Job Analysis, since it gives such an in-depth description of each job and/or task and complements the workers' compensation medical form (by whatever name it goes by) issued by your state (see Appendix B). (Note: New Hampshire has developed a specific Task Analysis Form, which it recommends to be completed when identifying temporary alternative duties—that form may also be found in Appendix B.)

Several of the forms/documents carry an inset box that briefly describes their purpose and/or use. Remember there is a set of reproducible "clean" forms/documents inserted into the pocket on the inside back cover.

Included in Appendix A are:

- Diagram: Processing an Injured Employee with/without Restrictions
- *Sample* Safety Policy Statement
- *Sample* Injury Reporting Procedures
- Job Analysis
- Physical Assessment Evaluation Form
- Physical Task Analysis Assessment
- Physical Assessment Survey
- Report of Injury/Incident
- *Sample* Transitional Duty Position Form
- Transitional Duty Agreement
- *Sample* Transitional Duty Offer
- *Sample* Letter to Physician/Medical Provider



Appendix A

Sample Safety Policy Statement

It is the policy of XYZ Company to provide all employees with a safe and healthy workplace. An effective health and safety program is an integral part of doing or being in business; it must be part of everything that takes place within our operation and it must be part of everyone's responsibility.

While the company must provide safe and healthful conditions for each of its employees, in return the company expects and insists that employees recognize their individual obligation to conduct themselves with due regard not only for their own safety but for the safety of their fellow employees as well.

To ensure that a safe working environment is maintained, all employees shall actively promote safety and accident prevention as an integral part of their normal job functions.

Each employee is responsible for implementing this policy by continually observing all safety practices, rules, and standards throughout the workday.

Since safety and efficient operations are integrated and inseparable, similar methods of control are required to address accident prevention as are used to maintain process quality and customer relations.

Of even more importance are the loss of earnings and the physical injuries suffered by employees as a result of accidents. These alone are factors which, in themselves, justify a constant and intensive accident prevention program.

The full cooperation of all employees is essential to successfully achieving the purposes of this safety policy.

Remember, all accidents and injuries can be prevented!

Appendix A

Sample Injury Reporting Procedures

Purpose:
To outline the steps involved in reporting injuries and to assign responsibility for each step.

Use:
To be included in a procedure manual, with company-specific adaptations.

In the event that you get injured
OR experience discomfort or pain while working,
the following steps must be followed:

1) If you are injured at work or think you have been injured as a result of work, contact your supervisor immediately.

2) With your supervisor, you will complete and sign the Employee Incident Report.

3) If medical treatment is required, or you request to see a doctor, you and your supervisor will go to _____.

4) The COMPANY NAME has chosen _____ as our Preferred Care Provider. We ask that you use _____ for your first visit. If after the first visit you wish to change medical providers, please contact Human Resources at _____ to obtain the proper form, fill it out, and return the completed form. If you neglect to use this process for seeking treatment with a provider other than _____, you will be responsible for the cost of that visit. (Note: This procedure holds true in Maine and Vermont.)

5) In the event that you need to be seen at the emergency room (ER), all follow-ups should be made through _____, then follow the process above if you wish to change providers after the first follow-up.

6) The medical provider will provide you with a form which lists your injury, treatment plan, and work capacity. You must return this form to your supervisor, who will use it to adjust your tasks to fit your restrictions.

7) Provide, in writing, to your supervisor a list of your follow-up appointments, with dates. IF you are unable to make a follow-up appointment, you must notify your supervisor a day before your appointment.

8) If you are removed from work by the doctor, you are responsible for keeping _____ informed of your current address, phone number, medical status, and follow-ups.

9) Only the doctor can remove you from work. If you have NOT been taken out of work by the doctor, and you feel you cannot do your transitional duty job, you MUST contact Human Resources immediately.

10) In this case, _____ will request that you be seen to reasses your injury and work status.

11) If you have any questions, contact your supervisor or Human Resources immediately.

12) AS ALWAYS, PREVENTION IS YOUR BEST COURSE OF ACTION.

I, the undersigned, agree that I have been provided the above injury-reporting procedures, understand my responsibilities for injury reporting and staying at work, and will abide by them to the best of my ability.

Employee Signature:_____ Date: ___ / ___ / ___

I, the undersigned, agree that I have provided and explained the above injury-reporting procedures to the injured employee.

Supervisor Signature:_____ Date: ___ / ___ / ___

Appendix A

Job Analysis Form

Employer: _____ Employee (if applicable): _____

Job Title: _____ Job Analysis Performed by: _____

Date: _____ Title: _____

Purpose:
To describe the physical demands and requirements of a job.

Use:
To be given to the medical provider.

1. Summary of job task:

_____

_____

_____

2. Skills/training required to perform duties (specify):

_____

_____

3. Work hours: _____ Overtime hours: _____ Numbers of days worked per week: _____

4. Machines, tools, equipment used as part of the job:

_____

5. Assess environmental factors employee is exposed to (circle most appropriate):

a. LOW TEMPERATURE *(lowest environmental temperature in which the employee will be required to work)*
   4. Work environment 40 – 60 F
   5. Work environment 15 – 40 F
   6. Work environment 15 F

b. HIGH TEMPERATURE *(highest environmental temperature in which the employee will be required to work.)*
   1. Work environment 70 – 80 F
   2. Work environment 80 – 90 F
   3. Work environment over 90 F

c. WET ENVIRONMENTS
   0. No exposure
   1. Occasional exposure to water or dampness
   2. Moderate exposure to water or dampness
   3. Constant work in/near water. Workers clothes always damp or wet

d. SLIPPERY SURFACES
   0. No exposure
   1. Occasional work on slippery surfaces (1-3 hrs/day)
   2. Moderate work on slippery surfaces (3-7 hrs/day)
   3. Constant work on slippery surfaces (7+ hrs/day)

e. UNEVEN SURFACES
   0. No exposure
   1. Occasional work on uneven surfaces (1-3 hrs/day)
   2. Moderate work on uneven surfaces (3-7 hrs/day)
   3. Constant work on uneven surfaces (7+ hrs/day)

f. HIGH ELEVATIONS *(unprotected exposure to heights)*
   0. No exposure
   1. Work up to 5 feet above the ground
   2. Work from 5-10 feet above the ground
   3. Work above 10 feet from the ground

g. CONFINED SPACES OR CRAMPED BODY POSITIONS
   0. No exposure
   1. Work in cramped positions/confined spaces (1-3 hrs/day)
   2. Work in cramped positions/confined spaces (3-7 hrs/day)
   3. Work in cramped position/confined spaces (7+ hrs day)

h. VIBRATION *(e.g., jackhammers, electric drills, sanders, etc.)*
   0. No exposure
   1. Minor vibration or short period of time (1-3 hrs/day)
   2. Some vibration or moderate period of time (3-7 hrs/day)
   3. Pronounced or continuous vibration (7+ hrs/day)

i. NON-IONIZING RADIATION *(welding flash, microwaves, sunburn)*
   0. No exposure
   1. Slight chance of exposure
   2. Moderate exposure
   3. Continuous/heavy exposure

j. IONIZING RADIATION *(radioactive isotopes, x-rays)*
   0. No exposure
   1. Slight chance of exposure
   2. Occasional exposure
   3. Continuous or heavy exposure

k. TOXIC CONDITIONS *(exposure to substances with known or suspected significant toxic health effects)*
0. No exposure
1. Slight likelihood of exposure
2. Moderate likelihood of exposure
3. High likelihood of exposure

l. INFECTION *(exposure to infections that can cause significant illness or death)*
0. No exposure
1. Minimal exposure to infections
2. Moderate exposure to infections
3. Frequent exposures to infections

m. NOISE
0. No exposure to loud noises
1. Slight—occasional fairly loud noises
2. Moderate—steady and fairly loud noise, level below 85dB
3. Severe—loud noise >85dB. Requires OSHA hearing protection

n. LIST TOXIC SUBSTANCES EMPLOYEES MAY BE EXPOSED TO:
_____
_____
_____

6. Moving equipment/vehicles driven as part of job? ❍ Yes ❍ No

7. Amount of each day spent: Standing _____% Walking _____% Sitting _____%

8. Employee works: Inside _____% Outside _____%

9. While performing job, employee required to:

a.	Drive	Yes ❍	No ❍
b.	Twist	Yes ❍	No ❍
c.	Stoop/Bend	Yes ❍	No ❍
d.	Squat	Yes ❍	No ❍
e.	Kneel	Yes ❍	No ❍
f.	Crawl	Yes ❍	No ❍
g.	Climb Ladders	Yes ❍	No ❍
h.	Climb Stairs	Yes ❍	No ❍
i.	Walk on uneven ground	Yes ❍	No ❍
j.	Work above shoulder level	Yes ❍	No ❍
k.	_____	Yes ❍	No ❍

10. The heaviest weight lifted while either sitting or standing in one place weighs _____. The object being lifted is called a _____ and is lifted an estimated _____times daily.

11. The heaviest weight carried while walking from place to place weighs _____. The object being carried is called a_____ and is carried an estimated _____times daily.

12. The heaviest weight pushed or pulled weighs _____. The object being pushed or pulled is called a _____ and is pushed or pulled a distance of _____ , an estimated _____times daily.

13. Physical activity required:

	TOTAL HOURS PERFORMED DAILY						
	Never	**1 or <**	**1-2**	**3-4**	**5-6**	**7-8**	**Constantly**
Lifting under 10 lbs.							
Lifting 10 – 25 lbs.							
Lifting 25 – 50 lbs.							
Lifting over 50 lbs.							
Carrying under 10 lbs.							
Carrying 10 – 25 lbs.							
Carrying 25 – 50 lbs.							
Carrying over 50 lbs.							
Reaching above shoulder height							
Reaching at shoulder height							
Reaching below shoulder height							

14. **Hand/wrist repetitions:**
    0. Not a requirement of this job
    1. Infrequent – 1-960/day (960 based on 2 repetitions/minute)
    2. Moderate – 961-2880/day (2880 based on 6 repetitions/minute)
    3. Frequent – 2881 or more (more than 6 repetitions/minute)

15. **Wrist position:**
    0. Not a requirement of this job
    1. Slight deviation of wrist
    2. Moderate deviation of wrist
    3. Extensive deviation

16. **Pinching:**
    0. Not a requirement of this job
    1. Infrequent – 1-120 pinches/day (120 based upon 15 pinches/hr.)
    2. Moderate – 121-480 pinches/day (480 based upon 1 pinch/minute)
    3. Frequent – 481 or greater pinches/day (over 1 pinch/minute)

17. **Does this job require use of both hands?** Yes ☐ No ☐

18. **If yes, amount of time job requires use of both hands:** _____

19. **Hearing:**
    0. Not a requirement of this job (a deaf person could perform this job)
    1. Requires hearing whispered voice at 3 feet (FAA Class III)
    2. Requires hearing whispered voice at 8 feet (FAA Class II)
    3. Requires hearing whispered voice at 20 feet (FAA Class 1)

20. **Near Vision (requirement to see objects close up):**
    0. Not a requirement of this job
    1. Requires minimal near vision
    2. Requires 20/40 near vision
    3. Requires 20/20 near vision

21. **Far Vision (requirement to see in the distance):**
    0. Not a requirement of this job
    1. Requires minimal far vision
    2. Requires 20/40 far vision
    3. Requires 20/20 far vision

22. **Visual Color Discrimination (match or discriminate between colors):**
    0. Not a requirement of this job
    1. Requires minimal color discrimination
    2. Requires discriminating between red, green and white
    3. Requires both red/green and blue/violet discrimination

23. **Visual Depth Perception (determine the distance and relationship between objects):**
    0. Not a requirement of this job
    1. Minimal depth perception required
    2. Moderate depth perception required
    3. Accurate depth perception required

24. **Can the worker change positions?** ❍ At will ❍ Occasionally ❍ Never

a. **Describe ways in which this job may be modified.**
If none, please explain: ❍ Permanent Modification ❍ Temporary Modification

26. **Employee comments/corrections (If applicable):**

I have reviewed this job analysis and agree with its content except for comments/corrections as noted above.

Employee's Signature *Date*

Physician comments/corrections (If applicable):

Is this job appropriate for this employee? ❍ Yes ❍ No

If no, please indicate why:

Physician's Signature *Date*

Appendix A

Physical Assessment Evaluation Form

An important aspect of (employer/company name) Stay-at-Work Program is returning an injured employee to work as soon as possible after the date of injury. Please provide the following information so that we can best determine the physical limitations of the worker and, if necessary, place the employee in a suitable, temporary modified job.

(Check one of the following):

1. ❑ Work Related ❑ Non-Work Related ❑ Shift Worked ❑ Other

Name of Employee	Date of Examination	Date of Next Appointment
Employee Social Security Number	Company Address	Company Phone Number

2. **Medication:** Please list any medication prescribed for use during working hours that would affect alertness or ability to respond to an emergency:

3. Referred to Dr._____ Date_____

   Lab_____ X-ray_____ Physical Therapy _____ Occupational Therapy _____

4. Diagnosis:_____

5. Physician's Comments:_____

6. Patient's Comments:_____

7. Work Ability: No Restrictions_____ Modified Work As Indicated Below_____

   Employee can work _____ hours per day.

   In a workday the employee can ____ for increments of up to ____ hours. (Circle applicable functions and hours restricted, if any, or check if no restrictions apply.)

Purpose:
To identify what an injured employee can and cannot do.

Use:
To be filled out by the medical provider and used by the employer to determine if a job needs to be modified or created to fit the employee's physical restrictions.

a. Sit	0,	1,	2,	3,	4,	5,	6,	7,	8,	☐ No Restrictions
b. Stand	0,	1,	2,	3,	4,	5,	6,	7,	8,	☐ No Restrictions
c. Walk	0,	1,	2,	3,	4,	5,	6,	7,	8,	☐ No Restrictions
d. Inside	0,	1,	2,	3,	4,	5,	6,	7,	8,	☐ No Restrictions
e. Outside	0,	1,	2,	3,	4,	5,	6,	7,	8,	☐ No Restrictions

Note: In terms of an 8-hour workday (Occasionally = 1% to 33%; Frequently = 34% - 66%; Continuously = 67% - 100%). Circle applicable functions and check time limitations, if any, or check if no restrictions apply.

a. Employee can lift:

	Never	Occasionally	Frequently	Continuously	No Restrictions
Up to 10 lbs.	❍	❍	❍	❍	❍
11-24 lbs.	❍	❍	❍	❍	❍
25-34 lbs.	❍	❍	❍	❍	❍
35-60 lbs.	❍	❍	❍	❍	❍
51-74 lbs.	❍	❍	❍	❍	❍
75-100 lbs.	❍	❍	❍	❍	❍

b. Employee can carry (lift and transport) an object 10 feet or more:

	Never	Occasionally	Frequently	Continuously	No Restrictions
Up to 10 lbs.	❍	❍	❍	❍	❍
11-24 lbs.	❍	❍	❍	❍	❍
25-34 lbs.	❍	❍	❍	❍	❍
35-60 lbs.	❍	❍	❍	❍	❍
51-74 lbs.	❍	❍	❍	❍	❍
75-100 lbs.	❍	❍	❍	❍	❍

c. Employee is able to:

	Never	Occasionally	Frequently	Continuously	No Restrictions
Bend	❍	❍	❍	❍	❍
Crouch	❍	❍	❍	❍	❍
Squat	❍	❍	❍	❍	❍
Push/Pull	❍	❍	❍	❍	❍
Crawl	❍	❍	❍	❍	❍
Climb Stairs	❍	❍	❍	❍	❍
Climb Ladders	❍	❍	❍	❍	❍
Reach Above – Shoulder Level	❍	❍	❍	❍	❍
Lift Above – Shoulder Level	❍	❍	❍	❍	❍
Balance	❍	❍	❍	❍	❍
Work on Uneven Ground	❍	❍	❍	❍	❍
Kneel	❍	❍	❍	❍	❍
Other	❍	❍	❍	❍	❍

Comments: (If applicable, note frequency per hour, per day)

d. Employee can use head and neck in:

	Never	Occasionally	Frequently	Continuously	No Restrictions
Static Position	❍	❍	❍	❍	❍
Frequent Flexing	❍	❍	❍	❍	❍
Frequent Rotating	❍	❍	❍	❍	❍

e. Employee can use hands for repetitive actions such as:

		Never	Occasionally	Frequently	Continuously	No Restrictions
Simple Grasping	Rt.	❍	❍	❍	❍	❍
	Lt.	❍	❍	❍	❍	❍
Firm Grasping	Rt.	❍	❍	❍	❍	❍
	Lt.	❍	❍	❍	❍	❍
Fine Manipulating (pinch gripping)	Rt.	❍	❍	❍	❍	❍
	Lt.	❍	❍	❍	❍	❍

f. Employee can use foot operated controls:

	Never	Occasionally	Frequently	Continuously	No Restrictions
Right	❍	❍	❍	❍	❍
Left	❍	❍	❍	❍	❍

g. Other (e.g. hearing or vision loss).

	Never	Occasionally	Frequently	Continuously	No Restrictions
	❍	❍	❍	❍	❍

I authorize the release of information concerning my present illness/injury to my employer and its workers' compensation insurance carrier.

Employee Signature _____ Date _____

Printed Physician Name, Address & Phone Number _____ Physician Signature _____

Appendix A

Physical Task Analysis Assessment

Employee: _____ Department: _____

Job Title: _____ Date of Analysis: _____

Specific Job Site: _____

NOTE: In terms of an 8-hour workday, "Occasionally" equals 1% to 33%, "Frequently" equals 34% to 66%, and "Continuously" equals 67% to 100%.

Purpose:
To determine the physical factors involved in performance of a job task.

Use:
To help the employer formulate and/or improve job descriptions and to serve as a communication tool with the medical provider.

1. General Description of Job:

2. Tools/Equipment Used:

3. Hours per Day Sitting _____ Standing _____ Walking _____

4. Employee Works: Inside _____ Outside _____

5. General Job Tasks Involve:

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
a. Bending/stooping				
b. Squatting/crouching				
c. Crawling				
d. Climbing stairs				
e. Climbing ladders				
f. Overhead work				
g. Kneeling				
h. Balancing				
i. Pushing/pulling				
j. Uneven work surfaces				
k. Twisting				
l. Awkward positions				
m. Confined spaces				
n. Fume exposure				

6. Hand/Wrist/Arm Tasks:

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
a. Radial/ulnar deviation				
b. Pronation/supination				
c. Grasping				
d. Pinching				
e. Vibratory tools				
f. Pulling				
g. Wrist flexion				
h. Wrist extension				
i. Fine manipulation				

7. Physical Activity Required:

	NEVER	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Lifting <10 lbs.				
Lifting 10-25 lbs.				
Lifting 25-50 lbs.				
Lifting > 50 lbs.				
Carrying <10 lbs.				
Carrying 10-25 lbs.				
Carrying 25-50 lbs.				
Carrying > 50 lbs.				
Reaching above shoulder				
Reaching at shoulder				
Reaching below shoulder				

8. Repetitive Motions Required:
9. Static/Awkward Postures:
10. Working Environment:
11. Comments:

Appendix A

Physical Assessment Survey

Department: _____

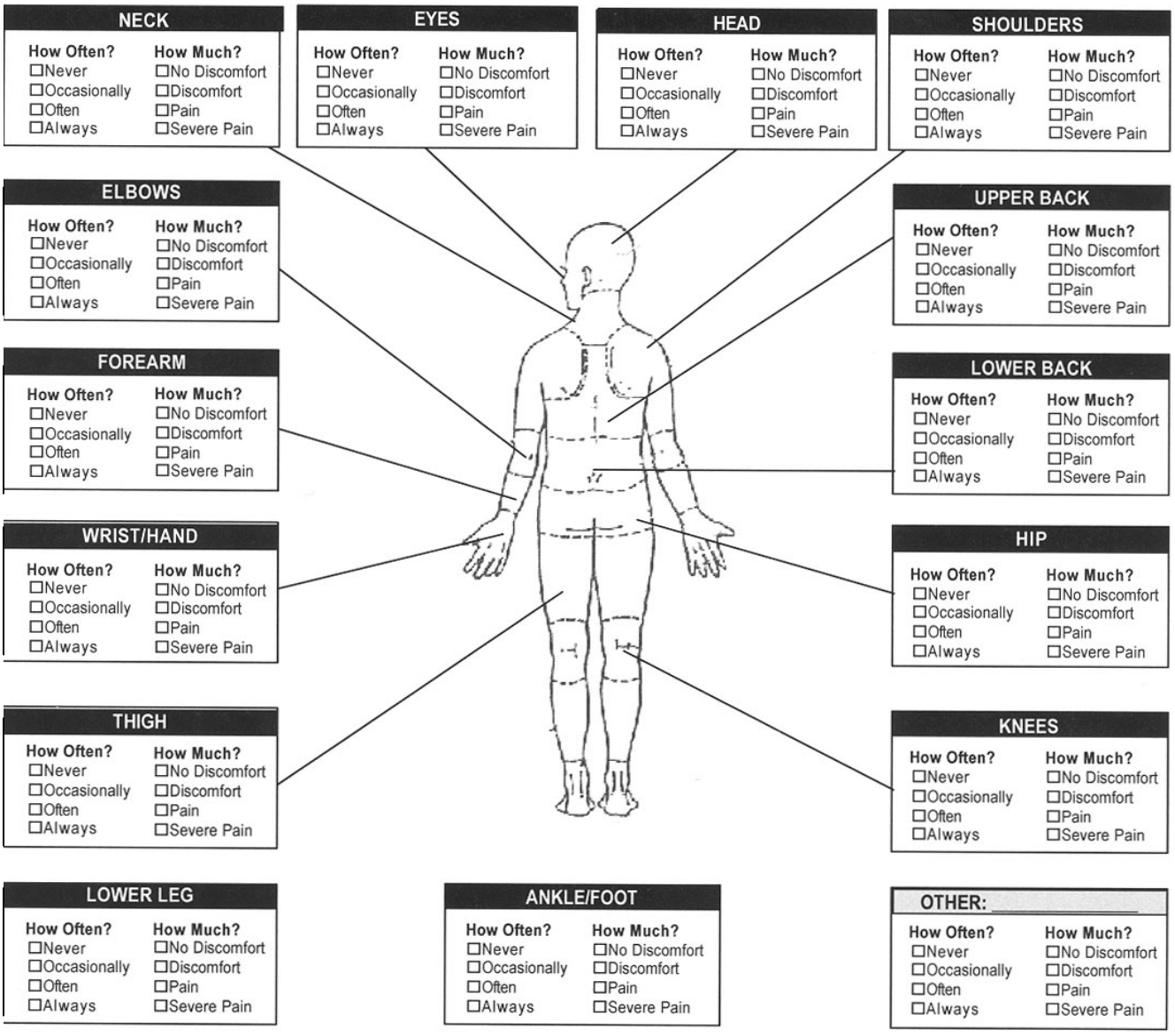
Job: _____

Date: _____

Do you experience discomfort or pain in any part of your body the day as you work or when you go home at night? ☐ Yes ☐ No

For each body part described in the boxes below:

1. Indicate how often you have discomfort in each body part.
2. Indicate the severity of discomfort.



Purpose: To measure the extent to which a job physically affects an employees.

Use: In-house tool that may indicate to the employer the need for a full-fledged ergonomics program.

Appendix A

Report of Injury/Incident

Purpose:
To document the occurrence, description, and preliminary findings of cause of an injury.

Use:
To pinpoint potential sources of hazards.

Name of Employee: _____ Address: _____

DOB: _____ SS#: _____

DOH: _____ Date/Time of Incident: _____

Job Title: _____ Where Incident Occurred (Unit/Room): _____

Reported to Supervisor: ☐ Yes ☐ No Date Reported: _____

Name of Supervisor: _____

1. Employee Complaints:

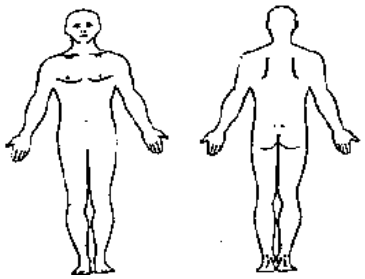
Was there an incident/accident? ☐ Yes ☐ No (If no, go to #2)

If yes, describe how the accident occurred/location of injury: _____

_____

2. Symptom Identification Chart:

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol and include all affected areas.



Numbness	+ + + + + +
Burning	X X X X X
Pins & Needles	0 0 0 0 0 0
Sharp Pain	/ / / / /
Dull & Aching	A A A A A
Weak	# # # # #

3. Immediate Signs of Distress:

☐ cut ☐ swelling ☐ faint ☐ black/blue discoloration ☐ rash ☐ burn ☐ puncture

☐ redness ☐ itching ☐ coughing ☐ other (Explain:_____)

4. Describe Discomfort/Pain:

☐ immediate onset ☐ delayed onset ☐ sharp ☐ aching ☐ pressure ☐ dull

☐ tightness ☐ running ☐ tingling ☐ numbness ☐ burning ☐ other

5. Movement Associated with Discomfort:

☐ bending ☐ reaching ☐ grasping ☐ sitting ☐ twisting ☐ pinching ☐ falling

___ pushing* ____ pulling* _____ lifting* (*approximate weight of object: ____ lbs.)

6. List all activities that produce discomfort:

_____ _____
_____ _____

7. Dynamics of an incident:

- Approximate weight of object/client involved _____ lbs.
- If lifting, object was lifted from _____ height to _____ height from the floor.
- Was anyone assisting with the task? ☐ Yes ☐ No
- Were any assistive devices being used? ☐ Yes ☐ No

8. Check accident cause(s) and comment as necessary. Circle specific factors.

Environmental Factors

☐ **A. Inadequate Safeguards** – Lack of handling or safety devices, unsafe designing, unguarded machinery.

☐ **B. Improper or Defective Equipment** – Poorly maintained equipment; worn, cracked, broken, rough, slippery agencies.

☐ **C. Hazards of Location** – Poor layout, congestion, insufficient space for storage, poor lighting, etc.

☐ **D. Poor Housekeeping** – Improper piling or placing, clutter; spillage or breakage.

☐ **E. Other** -

_____

Human Factors

☐ **F. Bodily Conditions –** Overweight, emotional upset, fatigue, intoxication, illness, age, poor eyesight, lack of strength, other physical handicaps**.**

☐ **G. Lack of Skill or Knowledge** – Improperly trained, inexperienced, uninformed, unaware, etc.

☐ **H. Misconduct** – Chance taking; insufficient interest; unauthorized or unnecessary use of equipment or tools, failure to use or deliberately making safety or control devices ineffective.

☐ **I. Improper Apparel** – Improper footwear, lack of personal protective equipment, loose sleeves, torn clothing.

☐ **J. Repetitive Motion/Overuse**

☐ **H. Other** -

_____

9. Patient Handling Incident:

Was this a:

Assistive Equipment Used:

- ☐ One-person transfer
- ☐ Two[person transfer
- ☐ Person lift (enter #)
- ☐ Transfer from bed to chair
- ☐ Transfer from chair to toilet
- ☐ Transfer from floor to chair

Patient Condition:

- ☐ Gait belt
- ☐ Walking belt
- ☐ Slide board
- ☐ Stretcher
- ☐ Sling
- ☐ Mechanical lift (type)

- ☐ Confuxed
- ☐ Fatigued
- ☐ Angry
- ☐ Able to talk
- ☐ Emotional status/behavioral problems
- ☐ Medicated
- ☐ In pain
- ☐ Frail/weak

Patient's Name:_____

10. Did the employee go to: ☐ employee health center ☐ family physician ☐ ER

11. Did the employee lose time? ☐ Yes ☐ No

Supervisor's Signature:_____

Appendix A

Transitional Duty Position Form

Employer Information

Employer: _____ Employee: _____

Tel # : _____ W.C. Insurer: _____

Employer Address: _____

Transitional Job Description

Job Title: _____

Description of Tasks:

1. _____
2. _____
3. _____

Description of Special Demands/Tools: _____

Purpose:
To evaluate the physical requirements of each task involved in a job assignment that the employer would like to provide for injured employees with temporary physical restrictions.

Use:
To be signed by medical provider to ensure that both employer and physician are working together on behalf of the injured employee.

Physical Demands

Complete the following to show the *maximum* physical demand for all of the tasks listed above. For example, if Tasks 1 through 4 require no bending but Task 5 requires "occasional" bending, the overall job must be rated as requiring occasional bending.

JOB REQUIRES:	Percentage of Day			
	Continuous 100% - 67%	Frequent 66% - 34%	Occasional 33% - 1%	None
Bending				
Kneeling				
Squatting				
Climbing				
Standing				
Walking				
Sitting				
Reaching				
Driving				
Fine Motor Skills				

JOB REQUIRES:
Maximum lifting/carrying of ____lbs.
Frequent lifting/carrying of _____ lbs.

WORK SCHEDULE:
Number of hours/day _____
Number of days/week _____

Does Job Require Repetitive Motions?				
	wrist	elbow	shoulder	ankle
Right				
Left				

Completed by _____ *Title* _____ *Date* _____

Physician (please print) _____ *Physician's Signature* _____ *Date* _____

Appendix A

Transitional Duty Agreement

Purpose:
To clarify the terms of the temporary duty, to formalize employee/supervisor acknowledgment of the terms, and to list any appointments scheduled for medical follow-up.

Employee Acknowledgment

I, _____, understand and agree to work within the limits as prescribed by the following medical provider:

Medical Provider: _____

The following transitional work activities as approved by the medical provider named above are specifically intended to ensure that I do not reinjure or aggravate the condition(s) for which I am being treated:

1. _____
2. _____
3. _____
4. _____

I understand that failure to work within these guidelines for transitional duty may result in disciplinary action.

_____ _____
Employee's Signature *Date*

Medical Follow-Up

Follow-up appointments and/or physical therapy are scheduled for the following dates and times:

Description	*Date*	*Time*

Manager/Supervisor Acknowledgment

The supervisor's signature below indicates that he/she has read and understands the above-listed guidelines for transitional duty and will ensure that work tasks assigned to the employee are within these restrictions.

Mgr./Supervisor (Print Name)	*Signature*	*Date*

Appendix A

Sample Transitional Duty Offer

To be sent on company letterhead via Certified Mail after offering transitional duty over the phone.

Purpose:
To acknowledge the restrictions ordered by the physician, to describe the temporary work position, to set the starting date and working hours, and to specify its location.

Date

Employee's Name
Street Address
City, State & Zip

Subject:

Dear _____:

I am writing to confirm our telephone conversation of today, (Date), in which I offered you a temporary assignment that takes into account your transitional work status resulting from your injury of (Date of Injury). This company is concerned about its employees' physical and financial well-being and we are pleased to be able to offer you a position which will allow you to earn more than you would on disability, while you are easing back to work. The job is with/at _____ located at _____. You indicated to me that you (would/would not) accept this position.

This position will start on (Date) and the hours are from (Time) a.m. to (Time) p.m. Should you be unable to appear at this appointed time, please contact me to make other arrangements at (Telephone Number).

Your treating physician has approved the physical requirements of this position. If you have any questions or concerns, please contact me personally.

Sincerely,

Name and Title

Appendix A

Sample Letter to Physician/Medical Provider

To be sent on company letterhead.

Purpose:
To affirm the employer's commitment to returning the injured employee to work and to establish the communication expectations between employer and provider.

Date

Physician's Name
Firm Name
Street Address
City, State & Zip

Subject: (Employee's name and date of injury)

Dear Doctor _____:

Our company has implemented a Stay-at-Work Program. As an employer, we are committed to accommodating restrictions resulting from an occupational injury. **Our goal is to help this employee return to the workplace in a productive capacity while he/she recovers, and we want to work with you to achieve this goal.**

Enclosed is a detailed job description for the regular job of the employee named above, which may be modified, if possible, to meet medical restrictions that may be assigned. If our employee is unable to return to his or her regular job, we will attempt to find an appropriate alternate work assignment. We will ensure that any assignment meets all medical requirements and that the above-named injured employee adheres to all medical restrictions.

If you have questions, please feel free to contact the undersigned or our insurance carrier.

Thank you for your participation in our efforts to return our employees to a safe and productive workplace.

Sincerely,

Name and Title

Enc: Job description and task analysis

Appendix B

The following pages contain forms, relevant statutory citation, and other information pertaining to workers' compensation specific to Maine, New Hampshire, and Vermont. In terms of a Stay-at-Work Program, the medical forms issued by each state are the most critical, and as mentioned earlier, complement the Job Analysis form (see Appendix A).

Included in Appendix B are:

- Maine
  - First Report of Injury (WCB-1)
  - M-1 – Practitioner's Report
  - Questions Frequently Asked about Workers' Compensation by Employees
  - Title 39-A, Section 202 – Injury or Death due to Willful Intention or Intoxication
- New Hampshire
  - Employer's Guide to Workers' Compensation
  - Temporary Alternative Work Regulatory Synopsis
  - First Report of Injury (Form 8WC)
  - Medical Form (75-WCA-1)
  - Medical Form Instructions
  - N.H. Workers' Compensation Task Analysis
  - Title 23, Section 281-A:14 – Employee's Fault
- Vermont
  - First Report of Injury (Form 1)
  - Work Capabilities Form (Form 20)
  - Frequently Asked Questions about Workers' Compensation by Employees
  - Title 21, Section 618 – Compensation for Personal Injury
  - Title 21, Section 649 – Injuries Not Covered; Burden of Proof

Maine

- First Report of Injury (WCB-1)
- M-1 – Practitioner's Report
- Questions Frequently Asked about Workers' Compensation by Employees
- Title 39-A, Section 202 – Injury or Death due to Willful Intention or Intoxication

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

1. WCB FILE NUMBER (if known):

1a. OSHA 300 CASE NUMBER (if applicable):

REASON FOR REPORT (check all that apply)

2a. ☐ LOST TIME - ONE OR MORE DAYS 2b. WAS EMPLOYEE PAID FOR ½ DAY OR MORE ON DAY OF INJURY? ☐ YES ☐ NO

3. ☐ LOST EARNINGS BUT NO LOST TIME 4. ☐ MEDICAL/HEALTH CARE 5. ☐ FATALITY DATE OF DEATH: ____/____/____ MM DD YYYY

6a. ☐ OCCUPATIONAL DISEASE 6b. DATE OF LAST EXPOSURE: ____/____/____ MM DD YYYY 6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: ____/____/____ MM DD YYYY

7a. ☐ CORRECT PRIOR REPORT 7b. DATE OF CORRECTION: ____/____/____ MM DD YYYY 7c. DATE CORRECTION SENT TO WCB: ____/____/____ MM DD YYYY

EMPLOYER

8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):	9. FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):		10. EMPLOYER NAME:	
11. STREET/P.O BOX MAILING ADDRESS:	12. CITY:	13. STATE:	14. ZIP:	15. TELEPHONE NUMBER: ( )
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:	17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:	18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:		

(check one) ☐ INSURER ☐ THIRD PARTY ADMINISTRATOR (TPA) ☐ SELF-ADMINISTERED EMPLOYER

19. INSURANCE / TPA COMPANY NAME:	20. POLICY NUMBER:		21. INSURER FILE NUMBER:	
22. STREET/P.O. BOX MAILING ADDRESS:	23. CITY:	24. STATE:	25. ZIP:	26. TELEPHONE NUMBER: ( )

EMPLOYEE

27. LAST NAME:	28. FIRST NAME:	29. MI:	30. TELEPHONE NUMBER: ( )	31. SOCIAL SECURITY NUMBER:	32. GENDER: ☐ MALE ☐ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:	34. CITY:		35. STATE:	36. ZIP:	37. DATE OF BIRTH: ____/____/____ MM DD YYYY
38. OCCUPATION/JOB TITLE:	39. DATE OF HIRE: ____/____/____ MM DD YYYY	40. WEEKLY WAGE AT TIME OF INJURY: $		41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? ☐YES ☐ NO IF YES, GIVE NAME AND ADDRESS:	

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: ____/____/____ MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	43. DATE OF INCAPACITY: ____/____/____ MM DD YYYY DATE EMPLOYER NOTIFIED: ____/____/____ MM DD YYYY	44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.): 46. TIME OF INJURY (e.g. 1:10 p.m.):	45. DATE EMPLOYER NOTIFIED INSURER/TPA: ____/____/____ MM DD YYYY 47. HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO IF YES, GIVE DATE: ____/____/____ MM DD YYYY

48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	49. BODY PART(s) AFFECTED (e.g. lower right forearm):	50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):

51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring.): WAS ACTIVITY PART OF NORMAL JOB DUTIES? ☐ YES ☐ NO	52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against hot metal.):

53. HOSPITALIZED OVERNIGHT AS INPATIENT? ☐ YES ☐ NO	54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO:	55. HEALTH CARE PROVICER NAME:	56. MAILING ADDRESS:	57. TELEPHONE NUMBER: ( )

PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):	59. TELEPHONE NUMBER: ( )	60. DATE SENT TO WCB: ____/____/____ MM DD YYYY

WCB-1 (01/02) THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY (877) 832-5525DISTRIBUTION: COPY (1) MAINE WORKERS' COMPENSATION BOARD, 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027, (2) EMPLOYEE, (3) INSURER, (4) EMPLOYER.

REASON FOR REPORT CIRCLE ONE INITIAL PROGRESS FINAL	M-1 PRACTITIONER'S REPORT STATE OF MAINE WORKERS' COMPENSATION BOARD Office of Medical/Rehabilitation Services	TYPE OF PRACTITIONER CIRCLE ONE MD DO DC LIST OTHER _____

EMPLOYEE

EMPLOYER NAME:	EMPLOYEE LAST NAME:	FIRST NAME:	M.I.:
EMPLOYER MAILING ADDRESS & PHONE #:	ADDRESS - NUMBER AND STREET:		
INSURER NAME:	CITY:	STATE: ZIP:	HOME PHONE:
INSURER MAILING ADDRESS:	DATE OF INJURY:	SSN:	
PATIENT'S COMPLAINTS:			

PRACTITIONER

ICD-9 CODE: _____

IN MY OPINION, THIS PROBLEM IS ☐ WORK RELATED ☐ NOT WORK RELATED ☐ IS NOT YET IDENTIFIED AS TO CAUSE

HAVE DIAGNOSTIC TESTS BEEN PERFORMED? ☐ YES ☐ NO RESULTS: _____

_____

DATE OF THIS EXAMINATION : ___/___/___ IS TREATMENT TO CONTINUE? ☐ YES ☐ NO

DATE PATIENT TO BE SEEN AGAIN: ___/___/___ ESTIMATED LENGTH OF TREATMENT? _____

TREATMENT PLAN: _____

LIST ANY MEDICATION PRESCRIBED FOR THIS DIAGNOSIS/CONDITION THAT WOULD PREVENT YOUR PATIENT FROM DRIVING AND/OR WORKING SAFELY:

_____

_____

IF UNABLE TO WORK, ADVISE ESTIMATED DATE OF RETURN : / / P.I. RATING : / /

WORK CAPACITY: ☐ REGULAR DUTY ☐ MODIFIED DUTY ☐ NO WORK CAPACITY

RESTRICTIONS YES/NO	DESCRIBE:

IS PERMANENT IMPAIRMENT EXPECTED? ☐ YES ☐ NO

HAS MMI BEEN REACHED? ☐ YES ☐ NO

_____ _____

SIGNATURE OF PRACTITIONER PRINT NAME AND ADDRESS

TELEPHONE #: _____ NARRATIVES ATTACHED? ☐ YES ☐ NO

Maine.gov

QUESTIONS AND ANSWERS

What should I do if I am injured at work? You must tell your employer (which can mean a supervisor or a member of management) as soon as possible that you have been injured.

When must I tell my employer that I have been injured at work? You must tell your employer within 90 days of your injury, or when you learn of your injury, that you have been injured. If you wait more than 90 days after the injury, you will lose the right to claim workers' compensation benefits.

What should my employer do when I report an injury? Your employer must complete a First Report of Injury within 7 days. Your employer must give you a copy of the First Report of Injury. If you lose a day's work because of your injury, your employer must also file the First Report of Injury with the Workers' Compensation Board. If your employer does not complete the First Report of Injury, you should call a regional office of the Workers' Compensation Board and ask to speak to a Troubleshooter.

Can I get medical help for my injury? Yes. For the first ten days, your employer has the right to select a health care provider to treat your injury. After the first ten days of treatment you may choose a different health care provider. You do this by telling your employer that you wish to have a different person treat your injury.

Can my employer ask me to see another doctor? Yes. Section 207 of the Workers' Compensation Act says that if you are treating with a health care provider of your own choice, your employer can require you to see a different doctor for another opinion. This is not the same thing as an Independent Medical Exam under Section 312, a process that is explained later in this guide.

Will my employer pay for any other medical costs? Yes. Your employer will pay for medicine and for mileage to and from your visits to health care providers. They will also pay for medical aids such as wheelchairs, crutches and hearing aids.

How long may I receive treatment for my injury? You can receive treatment until you recover from your injury. Your employer must pay for reasonable and proper treatment that is related to your injury.

If I need treatment while my employer disputes my claim, will my health insurer pay my bills? Yes. If the workers' compensation insurer will not pay your claim for medical treatment, you can submit the bills to your health insurer for payment. Your health insurer must pay the bills if the workers' compensation insurer is denying your claim and has not made any payments to you based on your claim.

What if I have to miss time from work because of my injury? If you miss more than 7 days of work because of an injury, you are entitled to receive weekly compensation benefits. If you lose between 7 and 13 days, you will be paid for those days. If you miss more than 14 days, you will

be paid for all of the days that you have missed. For example, if you miss 9 days of work, you would receive 2 days of benefits. If you missed 16 days of work, you would receive 16 days of benefits.

Will my employer pay me my full salary while I am out? No. If you were injured on or after January 1, 1993, your employer will pay you 80% of your after-tax average weekly wage. This is called your compensation rate. There is a limit on how much you can receive. Currently, the maximum benefit you can receive is $471.76 per week.

If you were injured prior to January 1, 1993, your employer will pay you 2/3 of your gross average weekly wage.

When does my employer have to decide if it is going to pay me for my lost time? Your employer must decide whether or not to pay your lost time claim within 14 days of the time you tell your employer about your injury.

What if my employer does not do anything for the first 14 days? If your employer does not dispute your claim within 14 days, it must begin paying you weekly compensation. Your employer must continue paying you at least until it files a Notice of Controversy.

How will I know if my employer is going to pay my claim? If your employer decides to pay your claim, it will send you a Memorandum of Payment.

My Memorandum of Payment says that my claim has been "accepted." What does that mean? This means that your employer agrees that you have been injured at work, and that you are entitled to benefits.

My Memorandum of Payment says that my "claim is voluntary payment pending investigation." What does that mean? This means that your employer is paying your claim even though it is not sure that your injury is work-related. This type of payment is often called "payment without prejudice."

What if I can work but I can not find a job? You may be entitled to receive 100% of your compensation rate if your injury stops you from returning to work. You can show that your injury prevents you from returning to work by doing a "work search", in other words, by keeping a list of the jobs that you have applied for but have not gotten.

What if I can go back to work, but I cannot earn as much as I used to earn? If you can return to work, but your injury stops you from earning as much as you used to earn, you may receive partial benefits. Partial benefits are equal to 80% of the difference between what your average weekly wage was before your injury and your earnings after you return to work.

Do I have to do anything when I return to work after an injury? Yes. If you are receiving compensation for your injury, you must notify the Workers' Compensation Board and the employer you were working for when you were injured that you have returned to work. You must do this within seven days of returning to work.

How long can I receive benefits for lost time? Regardless of your date of injury, if your incapacity is total, you may receive benefits for as long as you are unable to work. Total incapacity means that you are unable to work at all because of your injury.

If your incapacity is partial, and you were injured on or after January 1, 1993, you can, with a couple of exceptions, receive benefits for a maximum of 260 weeks. Partial incapacity benefits are due if you are able to work, but still have some restrictions on what you can do because of your injury. There are three exceptions to the 260 week limit on benefits. First, if your injury has caused more than 15% permanent impairment, you can receive benefits for as long as your injury lasts. Second, if you were injured between January 1, 1993 and January 1, 1998, and your injury has caused permanent impairment of 11.8% or greater, you can receive benefits for as long as your injury lasts. Third, you can ask the Workers' Compensation Board to order the employer to continue paying benefits after the 260 week cap has been reached. To do this, you must prove that you will suffer an extreme financial hardship because you cannot return to work.

If you were injured between October 17, 1991 and December 31, 1992, you may receive partial incapacity benefits for a maximum of 520 weeks.

If you were injured between November 20, 1987 and October 16, 1991, you may receive partial incapacity benefits for a maximum of 400 weeks after you have reached maximum medical improvement. (Maximum medical improvement means the date after which further recover is no longer reasonably anticipated.)

If you were injured prior to November 20, 1987, there is no limit on the amount of partial incapacity benefits you can receive.

Can my employer stop paying benefits without my agreement? Yes. If your claim is "accepted," your employer can stop paying benefits if you return to work for your employer, or if you receive an increase in pay from your employer. Your employer may also file a Petition for Review to stop or reduce your weekly benefits.

If your claim is being paid without prejudice, your employer can stop paying benefits if you return to work for your employer, or receive an increase in pay from your employer. In addition, the employer can stop your benefits by filing a 21-day certificate of discontinuance.

What is a 21-day certificate of discontinuance? If your employer is paying you without prejudice, it can notify you that it intends to discontinue weekly benefits no earlier than 21 days from the date that it mailed the notice to you. Your employer must state the reasons it is going to stop your benefits.

What can I do if I receive a 21-day certificate of discontinuance? You can file a Petition for Review and request a provisional order. When you file these forms, you will be asking a Hearing Officer to decide, within about 21 days, whether or not the employer should be able to stop your benefits before a hearing is held. You can contact a regional office of the Workers' Compensation Board and speak to a Troubleshooter who will help you fill out these forms.

What if my injury bothers me in the future? You can ask that your employer or your employer's insurer pay for more medical care and lost time. You can make a claim only if the statute of limitations on your claim has not run out.

What is the statute of limitations? The statute of limitations is the time limit within which you must file a claim for benefits. Once the statute of limitations expires, you cannot make a claim for further benefits. The statute of limitations is different for different dates of injury. If your employer makes a payment for workers' compensation benefits within two years of your injury or the last time they made a payment, your statute of limitations will not expire for at least two years. If they have not, you need to file a petition within two years of the date your employer filed a first report of injury with the Workers' Compensation Board. There are certain cases where a longer period between payments can go by without your statute of limitations expiring. If you have questions about your statute of limitations, you should call a regional office of the Workers' Compensation Board and ask to speak to a Troubleshooter.

What if my employer refuses to pay my claim? If your employer refuses to pay your claim they will file a Notice of Controversy. A Notice of Controversy is often called a "NOC". The Notice of Controversy should indicate why the employer is not agreeing to pay your claim.

What happens if my employer files a Notice of Controversy? If your employer files a Notice of Controversy, your case will be sent to a Troubleshooter. The Troubleshooter will try to contact both you and your employer and try to resolve the disagreement. If you receive a Notice of Controversy, and you do not hear from a Troubleshooter within 2 weeks, you should call a regional office of the Workers' Compensation Board and ask to speak to a Troubleshooter.

What if the Troubleshooter cannot resolve the dispute? If the Troubleshooter cannot resolve the dispute, then your case will be sent to a Mediator. The Mediator will meet with you, your employer and the employer's insurance company. The meeting will be held in an informal setting. The parties, with the mediator's help, will attempt to come to an agreement. The Mediator will not take sides at the mediation. Any agreements you reach must be reached voluntarily.

If my case is sent to mediation, will someone be available to help me? Yes. There are Worker Advocates at each regional office who help injured workers with their claims. You can receive assistance from a Worker Advocate if you were injured on or after January 1, 1993, have participated in troubleshooting, do not have an attorney, and request the services of a Worker Advocate. The addresses and phone numbers of the Worker Advocate offices are listed at the back of this guide.

What will the Worker Advocate do? The Worker Advocate will help you prepare for mediation, and will attend mediation with you. They will also help you negotiate with your employer to resolve your dispute.

Can I get a lawyer to help me? Yes. If you were injured on or after January 1, 1993, you will be responsible for paying your attorney for his or her services.

If you were injured prior to June 30, 1985, your employer will pay your attorney's fees if yo make a claim in good faith, or if your employer begins the process.

What if the Mediator cannot resolve the dispute? If the Mediator cannot resolve the dispute, then either you or your employer can file petitions that request a formal hearing. There are different petitions which you can use to request different benefits. For example, if you want your employer to pay lost time benefits, then you would file a Petition for Award. If you want your

employer to pay medical bills, then you will file a Petition to Fix. These forms are available at the different regional offices.

After an unsuccessful mediation, you, your employer, or a Hearing Officer may request an independent medical exam. Independent medical exams are explained later in this guide.

Will the Worker Advocate be able to help me after the mediation? Yes. If your claim goes to formal hearing, the Worker Advocate will help you prepare for the hearing, and will attend the hearing with you.

What is a formal hearing? The formal hearing is your opportunity to present your case to a Hearing Officer. The Hearing Officer will listen to your evidence, and the evidence that your employer wants to present. After the Hearing Officer has heard all of the evidence, the Hearing Officer will write a decision. The decision is binding on you and your employer.

What if I disagree with the Hearing Officer? You may appeal the decision of the Hearing Officer to the Supreme Judicial Court of Maine. (The Supreme Judical Court is also known as the " Law Court".) The Supreme Judicial Court does not have to hear your appeal. They can choose which cases they want to hear.

What is an independent medical exam? When a request for an independent medical exam is granted, the Workers' Compensation Board will ask a doctor to examine you, and whatever records you and your employer want him/her to. The independent medical examiner will write a report that explains whether or not your injury is related to work. The independent medical examiner's decision will be binding on you and your employer if you agreed on an examiner. If the Workers' Compensation Board appointed the examiner, the examiner's decision will be binding unless there is clear and convincing evidence that the examiner's findings are wrong.

What is the difference between an independent medical exam under Section 312 and a medical exam under Section 207? An examination under Section 207 is an examination by a doctor that your employer has chosen. The doctor's medical opinion is not binding on the parties. An independent medical exam is an exam under Section 312 by a doctor that the Workers' Compensation Board has chosen. Unlike a Section 207 exam, the findings of an independent medical examiner are binding unless there is clear and convincing evidence that the examiner's findings are wrong.

Does my employer have to give me my job back? If you are able to return to work, and your job is open, your employer must offer you your previous job. If your old job has been filled, or if your injury prevents you from doing that job, your employer must give you a job that you can do even with your injury. Your employer must also make reasonable accommodations for your injury. That means that your employer must make changes to a job that will allow you to return to work, as long as the changes would not impose an undue hardship on your employer.

What if I cannot return to my old job, and there is no other work at my employer's business? If you cannot return to your old job because of your work related injury, you may be entitled to receive vocational rehabilitation. Vocational rehabilitation may include job retraining and job placement.

What if my employer will not pay for vocational rehabilitation? If your employer will not voluntarily pay for vocational rehabilitation, you can ask the Workers' Compensation Board to recommend a vocational rehabilitation plan. If your employer refuses to pay for the plan, the Workers' Compensation Board will pay for you to go through with the rehabilitation plan. You will not be responsible for any of the cost of a plan that the Workers' Compensation Board pays for.

Can my employer discriminate against me if I file a workers' compensation claim? No. Your employer cannot discriminate against you for filing a workers' compensation claim. Your employer cannot discriminate against you for testifying in a workers' compensation claim. If you think your employer has discriminated against you because you filed a claim or testified, you can file a Petition to Remedy Discrimination.

Are there penalties in the Workers' Compensation Act? Yes. Employers and employees can be penalized for not filing required reports and forms, and for not filing required reports and forms, and for willful violations of the Workers' Compensation Act, fraud or intentional misrepresentation. Employers can be penalized for making late payment of benefits.

Where can I get more information? You can get more information at any one of the regional offices listed at the front of this guide.

What are the addresses and phone numbers of the worker Advocate offices? The addresses and phone numbers of the Worker Advocate offices are listed below. If you have not spoken to a Troubleshooter, please use the addresses and phone numbers listed at the beginning of this guide. If you have already spoken to a Troubleshooter, and need to contact a Worker Advocate, please use the addresses and phone numbers listed below.

AUGUSTA
24 Stone Street
Augusta, ME 04330-5220
(207) 287-2266
1-888-645-2266 (Maine only)

BANGOR
106 Hogan Road
Bangor, ME 04401-5640
(207) 941-4556
1-888-594-4556 (Maine only)

CARIBOU
One Vaughn Place
10 Washburn Ave, Suite 110
Caribou, Maine 04736-2347
(207) 498-6428 or 800-400-6855
(Maine only)

LEWISTON
36 Mollison Way
Lewiston, Maine 04240-7761
(207) 753-7700 or 800-400-6857 (Maine only)

PORTLAND
62 Elm Street
Portland, Maine 04101-0840
(207) 822-0840 or 800-400-6858 (Maine only)

§202. Injury or death due to willful intention or intoxication

Compensation or other benefits are not allowed for the injury or death of an employee when it is proved that the injury or death was occasioned by the employee's willful intention to bring about the injury or death of the employee or of another, or that the injury or death resulted from the employee's intoxication while on duty. This provision as to intoxication does not apply if the employer knew at the time of the injury that the employee was intoxicated or that the employee was in the habit at that time of becoming intoxicated while on duty. [1991, c. 885, Pt. A, §8 (NEW); 1991, c. 885, Pt. A, §§9-11 (AFF).]

SECTION HISTORY
1991, c. 885, §A8 (NEW). 1991, c. 885, §§A9-11 (AFF).

New Hampshire

- Employer's Guide to Workers' Compensation
- Temporary Alternative Work Regulatory Synopsis
- First Report of Injury (Form 8WC)
- Medical Form (75-WCA-1)
- Medical Form Instructions
- N.H. Workers' Compensation Task Analysis
- Title 23, Section 281-A:14 – Employee's Fault

EMPLOYER'S GUIDE

TO

WORKERS' COMPENSATION

State of New Hampshire
Department of Labor
State Office Park South
95 Pleasant Street
Concord, New Hampshire 03301
(603) 271-3176

INTRODUCTION

This booklet has been prepared in an effort to assist employers in handling the reporting of employee's on the job injuries or occupational illnesses. Just as your worker has relied upon you for his/her regular paycheck, the injured worker also relies upon your prompt handling of his/her workers' compensation claim so that suitable medical care is not delayed and family income is not interrupted. Therefore, once an injury has occurred, the employer should do everything possible to assure that the provisions of the New Hampshire Workers' Compensation law are carried out. Injuries treated properly and promptly result in the continuation of a good employer-employee relationship and the timely return to work of an experienced employee.

Familiarity with the guidelines presented in this booklet will assist you in meeting your responsibilities as an employer under RSA 281-A, the New Hampshire Workers' Compensation Law. If you have questions about your rights or responsibilities under this law, please contact our staff at the Department of Labor for assistance.

The following information is based upon the provisions of the New Hampshire Workers' Compensation Law, RSA 281-A, and the New Hampshire Code of Administrative Rules, Chapter Lab 300 and 500.

What is Workers' Compensation?

Workers' Compensation is an insurance program that pays medical and disability benefits for work-related injuries and diseases. If injured on the job, an employee's medical treatment costs will be paid by the policy; if disabled following an on the job injury, the employee will also receive weekly income through the policy until able to return to work. All employers must obtain coverage by purchasing an insurance policy through the insurance agent or company of their choice, unless they become licensed to "self-insure" by the Commissioner of Labor. Workers' compensation insurance programs protect both employees and employers. Each covered employee has the right to benefits if injured on the job. In return, the employee forfeits the right to sue the employer for the job related injury.

Purchasing Workers' Compensation Coverage

The primary responsibility for obtaining workers' compensation insurance coverage rests upon employers who must apply for and obtain coverage prior to the hiring of any employee. Insurance agencies and carriers, however, share in this coverage responsibility, beginning with their receipt of an application for coverage. If an agency or carrier refuses to provide coverage on a voluntary basis, they must advise the employer about the availability of coverage under the Assigned Risk Plan of the National Council of Compensation Insurance and must also provide the necessary application form.

After coverage is in effect, the employer will receive from the insurance carrier a NOTICE OF COMPLIANCE, Form No. WCP-1, which needs to be posted in a conspicuous spot in the place of business. This poster contains basic information regarding the rights and responsibilities of both employer and employees, as well as the name of the insurance carrier underwriting the workers' compensation coverage.

The only business exempt from the requirement to purchase workers' compensation coverage are sole proprietorships (self-employed persons) and corporations which have **only** three corporate officers and **no** employees other than these three officers.

There is often confusion about the respective responsibilities of employers and subcontractors in providing workers' compensation coverage for workers. If you utilize the services of subcontractors in your business, be certain that any subcontractors you use have arranged to provide required workers' compensation coverage for their employees. Otherwise, you may be held liable to the compensation of any injuries that occur to the subcontractor's employees.

What is the Insurance Company's Responsibility to the Employer?

It is the insurance company's responsibility to provide an employer who has purchased insurance coverage with a poster (Notice of Compliance) and a supply of the forms that will be needed to report and process a claim. These forms included the following:

1) **Notice of Accidental Injury or Occupational Disease** (Form No. 8aWCA). This form is used by an employee to provide the employer with written notice that s/he has sustained an on the job injury or believes that s/h has developed an occupational illness. This form does not necessarily need to be completed before the Employer's First Report of Injury or Occupational Disease (see below) is filed; an employee's verbal notification to his/her employer that an injury has occurred is sufficient initially.

2) **Employer's First Report of Injury or Occupational Disease** (Form No. 8-WC). This form is to be completed by the employer within five **calendar** days (not working days) of learning of an employee's work-related injury or illness and is used to notify the Department of Labor and the insurance company that an employee injury has been reported. The employee's report may be either verbal or written. If the employer considers the claim to be questionable, the employer must still file the report promptly, but may wish to outline his concerns about the legitimacy of the claim in a note attached to the insurance company's copy of this report. (See below for a further discussion of this matter.)

3) **Employer's Supplemental Report of Injury** (Form No. 13 WCA). The employer uses this form to report to the Labor Department and the insurance carrier that an employee's occupational illness or injury has resulted in lost time from work (disability) of four or more days. It is also used when an employee who was disabled by a work-related injury or illness returns to work. It should be used to clarify lost time if the First Report of Injury is not clear.

4) **Wage Schedule** (Form No. 76 WCA). In the event that an employee becomes disabled from a work-related injury or illness, this form will need to be completed and both copies mailed to the insurance carrier so that the injured employee's workers' compensation rate can be properly calculated. Wage information from the 26 weeks prior to the injury, or the rate of hire for employees who have not worked a full 26 weeks, should be used to complete this form.

An employee who is employed by two or more employers in the State of New Hampshire at the time of injury may be subject to the combined earnings provision of the statute. If one of your employees was hurt while working at their other employers, s/he may request that you complete a wage schedule for the calculation of their wages by the carrier covering the other employer and paying workers' compensation benefits.

5) **Supplemental Wage Schedule** (Form No. 76 WCA 1). If requested by the insurance carrier, this form should be completed by the employer and signed by the employee. This form is necessary for the calculating of "after tax earnings".

Please be certain to keep a supply of these forms on hand at all times so that they are readily available when you need them. Forms are available through your insurance carrier; your supply should also be renewed any time that you change insurance carriers. (A complete explanation of when and how to file each form follows in the next section, "What to do When An Employee Is Injured".)

Additionally, the insurer is also responsible for keeping its insured employers informed of the address of the nearest insurance claims office. Upon receipt of employers' reports, the insurer must also review each claim promptly and critically to determine, as soon as possible after the onset of the disability, if the reported claim is compensable.

What To Do When An Employee Is Injured

It is important that, as an employer, you inform your employees about their rights and responsibilities under the New Hampshire workers' compensation law. We suggest that you clearly identify for your employees the individual(s) within your company to whom you want any on-the-job injuries to be reported; this will help avoid confusion when an injury occurs.

***First Aid Log**

"First Aid" is defined as any one time treatment that generated a bill less than $750.00 and results in no lost time. These "first aid only" injuries **must** be reported to the Labor Department on the Employer's First Report of Occupational Injury or disease

(Form 8WC). If you do not send these types of reports to the insurance carrier then it must be mailed to the Department of Labor. If the employer contests the "first aid only" injury, it must be reported to both the Labor Department and the insurance carrier.

***Employer's First Report of Injury or Occupational Disease (Form No 8WC).**

If an injury requires treatment beyond common first aid (that is, if any medical cost of over $750.00 or disability is involved), the employer or their insurance carrier must send the Employer's First Report of Injury (Form No. 8WC) to the Department of Labor, which must be filed electronically by the insurance carrier or their agent, within five **calendar** days of the employee's notice to the employer that an incident has occurred.

Occasionally, an injury that requires only common first aid treatment at the time of injury will later require more extensive medical attention. In these cases, the injury becomes reportable at the time that the employer learns of the additional medical treatment. In such cases, complete the employer's First Report of Injury, being certain to note the date on which you, as the employer, become aware that additional medical attention was sought and notify the Labor Department that this is no long a first aid injury. Then, send the Employer's First Report of Injury (Form No. 8WC), which must be filed electronically by the insurance carrier or their agent, to the Labor Department and to the insurance company within the five calendar day limit.

***Notice of Accidental Injury or Illness** (Form No. 8aWCA)

The employer must, additionally, have the employee fill out Form No. 8aWCA, the Notice of Accidental Injury or Illness, at the earliest opportunity. It is, of course, not always practical to have the employee fill out this form immediately; but at the earliest reasonable time, the employee should be provided with a form to complete for his/her and the employer's records. **Absence of this written notice of an injury or illness does not excuse the employer from reporting the injury within the prescribed time frame.**

The employer copies of these two forms, No. 8 WC and No. 8aWCA, are to be kept on file by the employer for five years from the date of injury.

***Employer's Supplemental Report of Injury** (Form No. 13WCA)

If an employee's work-related injury or illness results in disability of four or more calendar days, the employer needs to notify the Labor Department and insurance carrier of this disability by filing Form No. 13 WCA, the Employer's Supplemental Report of Injury. When mailing the canary/yellow copy of this supplemental report to the insurance carrier, the employer needs to attach Form No. 76 WCA, the Wage Schedule (see below).

***Wage Schedule (Form No. 76WCA)**

Both copies of the Wage Schedule must be sent to the insurance carrier who will, in turn, send one copy on to the Department of Labor along with a memorandum noting what amount of compensation has been paid and the date on which it was paid.

The information contained in a completed wage schedule is used to calculate the average weekly wage of the employee; this figure will, in turn be used to compute the rate of the injured workers' compensation benefits. The form asks the employer to provide wage information based upon gross wages, including bonuses for the periods to which such payments apply. When applicable, also include the reasonable value of board, rent, housing, lodging, fuel or other similar advantages that you furnish to your employee as part of the contract of hire.

The intent of this is to generate a representative listing of the employee's wages based upon earnings during the 26 consecutive weeks preceding the injury. Sometimes, this method of calculating wages does not yield an accurate picture of an employee's earnings. For example, if your employee usually worked eight hours of overtime each week, but six weeks prior to his/her injury all overtime was cut; in such a case, the employee's wages schedule would show lower weekly wages than s/he usually earned. Another example might be a construction worker injured one month after returning to work from winter lay off; this worker's wage schedule would not provide information indicative of his usual earnings since he had not worked for the full 26 week period. In these unusual cases, you may go back 52 consecutive weeks prior to the date of injury and use wages earned during that entire period of time, as long as the difference in the resulting average weekly wage figure is to the advantage of the employee.

***Questionable Claims**

The employer's filing of these reports shall in no way prejudice the employer's rights to contest the compensability of the claim at a later date. Please remember, the insurance carrier has a responsibility to the employer to investigate each claim at a later date. Please remember, the insurance carrier has a responsibility to the employer to investigate each claim thoroughly and promptly to determine whether or not the claim is legitimately compensable. If you, as the employer, believe that a claim is questionable, do not delay in filing the required reports; simply fill out the Employer's first Report of Injury as completely as you can and mail it to the Department and the insurance carrier within the required time limit. Attach a note to your carrier's copy of the report, alerting them to your concerns about the claim. The carrier will carry on from there.

***Temporary Alternative Duty and Reinstatement of Employees Sustaining Compensable Injuries**

Employers are responsible for providing alternative duty for employees injured on the job. Modified work shall be established in accordance with the attending health care provider's form, as completed with each visit.

Employees may be entitled to reinstatement to their regular job when released to full work capacity (in accordance with their regular job) within 18 months of their work related injury or illness.

***Job Modification Reimbursement**

There are occasions when an employee who has filed a First Report may need to have his work station ergonomically adjusted. As an employer, you can request reimbursement for up to 50% of the costs incurred for the job modification for this employee. This process requires the prior approval of a plan for modification by the Department. For an application and further information, please contact the Vocational Rehabilitation staff at the Department of Labor.

***Occupational Safety and Health**

Workers' Compensation reform legislation adopted in 1994 created the Safety Section with the Department to educate and assist employers in workplace safety and health. This law was established to create a more cooperative effort between management and labor in the evaluation and resolution of safety and health concerns in the workplace. RSA 281-A:64 requires the formulation of Joint Loss Management Committees, evaluation and resolution of safety concerns and Written Safety Programs.

Priority inspections will be determined by first visiting those employers who have not submitted the required summary of their written safety program, and secondly, those companies who have a high "experience modification" as determined by National Council of Compensation Insurance (NCCI 1992-1993). Administrative Rules for Safety Inspections in conjunction with this law have been promulgated by a committee representing both public and private employers, as well as labor organizations, state and local government. The rules committee is utilizing injury data from both the public and private sections over the last 3 years to focus their rulemaking on prevention of those injuries and illnesses occurring most frequently.

Employers with 5 or more employees are required to form a joint loss management committee (JLMC) consisting of equal membership from both labor and management staff. Employees choose their own representatives. Committees are to meet at least quarterly and maintain "minutes" of all meetings.

Those employers with 10 or more employees in addition to establishing their joint loss management committee are required to submit a Safety Summary Form reflecting their established safety program to the Department of Labor every other year; due on h January 1. Summary forms and instructions are available from the Safety Section of the Department of Labor.

New Hampshire Temporary Alternative Work Regulatory Synopsis

Statute – RSA 281-A:23-b. Alternative Work Opportunities
All employers with 5 or more employees shall develop temporary alternative work opportunities for injured employees. If the employee fails to accept temporary alternative work, the employer may petition the commissioner pursuant to RSA 281-A:48, to reduce or end compensation. Notwithstanding RSA 281-A:22, if an injured employee returns to temporary alternative work within 5 days of sustaining the injury, such employee shall be paid workers' compensation from the first date of the injury. The commissioner shall adopt rules under RSA 541-A relative to the administration of this section.

Administrative Rule – Lab 504.04. Development of Temporary Alternative Work

a. All employers with 5 or more full time employees shall provide temporary alternative work programs to bring injured employees back to work.

b. Temporary alternative work shall be limited and transitional in nature. For the purpose of this provision, transitional means the duty elements are variable as the employee's work capacity increases.

c. The employer shall advise employees that there is a written alternative work program in place and advise employees of the established procedures to obtain alternative work in the event of an on-the-job injury.

d. The employer shall develop an outline of each position that details present requirements and essential functions of each job within the organization at the time of injury if lost time or restrictions are involved.

e. The employer shall review each position outline in conjunction with its joint loss management committees as described in Lab 603. This review shall begin with those positions which experience most workplace injuries. Together they shall develop and describe a policy or process that facilitates return to work.

f. The employer shall provide the treating physician with the appropriate outline of the present position with an essential task analysis as soon as possible after the injury occurs if lost time or restrictions are involved. The employer and employee shall have a joint responsibility to obtain needed medical information that will enable the employee to gradually increase his/her duties and bring the employee back to his/her original position.

g. The employer shall offer a position as approved by the treating physician and the employee shall demonstrate a reasonable effort to comply.

This form must be printed and sent to the NH Department of Labor and your insurance carrier.

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE (Form 8WC)

NH DOL USE ONLY

Return to: **The State of New Hampshire, Department of Labor**
P.O. Box 2077, Concord, NH 03302-2077
(603) 271-3176 FAX: (603) 271-6149

IMPORTANT; *Every employer shall file this report as soon as possible after knowledge of any occupational injury or disease to an employee, but no later than five days thereafter. Notice of disability of four or more days shall be filed no later than seven days after date of injury on Supplemental Report Form No. 13WCA. Failure to comply with any or all of the above carries a civil penalty of up to $2,500.00. RSA 281A:53.*

PLEASE TYPE OR PRINT. ILLEGIBLE OR INCOMPLETE FORMS WILL BE RETURNED.

EMPLOYEE INFORMATION

1. Name of injured: First Middle Initial Last
2. DOB:
3. Age:
4. Male _ _ Female _ _
5. SS No.:
6. Address: No. & St. City/Town
7. State:
8. Zip Code:
9. Tel. No.:
10. Is there on file a N.H. Youth Employment Certificate?:
11. Occupation when injured:
12. Was this his/her regular occupation? If not, state regular occupation:
13. Wages per hr.:
14. No. hrs. worked per day:
15. No. days worked per week:
16. Average Weekly Earnings:
17. Was injured hired in N.H.?
18. Date employment began:
19. Date & Time of Injury:
20. Date disability began:
21. Was injured paid in full for this day?
22. Date supervisor/employer was first notified:
23. Name of Person notified:
24. Location/Jobsite where accident occured:
25. Describe fully how accident occurred and describe what employee was doing when injured:
26. Name of witness(es):
27. Part(s) of body injured:
28. Estimated length of disability:
29. Has injured returned to work?
30. If so, what date?
31. At what occupation or job?
32. Returned at: Full Duty: ____ ____ Alternative/Light Duty: ____ ____
33. Equipment causing injury:
34. Were safeguards in place?
35. Was accident caused by injured's failure to use safeguards or follow regulations?
36. Initial Treatment: (check those that apply) No medical treatment: _ _ Care provide by Employer only (on-site): _ _ Emergency care: _ _ Hospitalized: _ _
Other: (Outpatient): _ _ (Clinic): _ _ (Office Visit): _ _ (Other-explain): _____
37. Name of treating physician: Name of treating hospital:
38. Has injured died? If so, what date?

EMPLOYER INFORMATION

39. Legal Business Name and/or D/B/A or Leasing Company Name:
40. Employers Federal ID:
41. If leased or temporary worker, client's business name:
42. Business Address of No. 39 above:
43. City/State:
44. Zip:
45. Telephone Number:
46. Insurance Co. (**not agent**) or Self Insured Group:
47. Managed Care Program? Y or N. If yes, name Provider:
48. No. of Employees: Full-time: Part-time:
49. Is there a Written Safety Program **in force**?
50. Is there an **active** Safety Committee?
51. Business SIC Code
52. Type or Nature of Business in N.H.:
53. If report sent by Insurance Agency, state name:
54. Employer Signature:
55. Printed/Typed Name and Official Title:
56. Employee Signature (**whenever** possible):
57. Date of this report:

NEW HAMPSHIRE WORKERS' COMPENSATION MEDICAL FORM

This form must be completed at each health professional visit (MD, DO, DC or DDS) and must be filed with the worker's compensation insurance carrier within 10 days of the treatment (first aid excluded). Failure to comply and complete this form shall result in the provider not being reimbursed for services rendered and may result in a civil penalty of up to $2,500.

In compliance with RSA 281-A:23-b, the employer with 5 or more employees must provide temporary alternative/transitional work opportunities to all employees temporarily disabled by a work related injury or illness.

Employee _____ Employer _____

SS # _____ Work telephone # _____

Occupation _____ Employer contact _____

Date last worked _____ Employer address _____

W.C. insurer _____ _____

HEALTH PROFESSIONAL TO COMPLETE

☐ Initial visit ☐ Follow-up visit Date of injury _____ Time _____

Worker's statement of the incident _____

Worker's complaints _____

Diagnosis/Prognosis _____

Treatment plan _____

_____

In your opinion is this injury and disability as a result of injury described above? ☐ Yes ☐ No ☐ Unclear

EMPLOYEE WORK CAPABILITY

☐ Continue Working Can return to work: ☐ Yes Date _____ ☐ No

☐ Full Duty ☐ With Modification. If so, for what duration? _____

Employee can	No Restrictions	Frequently	Occasionally	Unable to
bend				
kneel				
squat				
climb				
stand				
walk				
sit				
reach				
drive				
do fine motor				

No repetitive motions		Wrist	Elbow	Shoulder	Ankle
	Right				
	Left				

Employee can lift/carry maximally _____ lbs.
Employee can lift/carry frequently _____ lbs.

Employee can work a maximum of #___ hours/day, #___days /wk.
What special accommodations are required? _____
_____

Other _____
Has employee reached maximum medical improvement?
☐ Yes ☐ No
Has injury caused permanent impairment?
☐ Yes ☐ No ☐ Undetermined

ALL MEDICAL NOTES MUST BE ATTACHED TO BILL

I certify that the narrative descriptions of the principal and secondary diagnosis and the major procedures performed are accurate and complete to the best of my knowledge.

_____ _____ _____
Provider's signature Provider's Printed name Provider's telephone#

_____ _____
Federal ID# Date of visit

MEDICAL AUTHORIZATION: The act of the worker in applying for workers' compensation benefits constitutes authorization to any physician, hospital, chiropractor, or other medical vendor to supply all relevant medical information regarding the worker's occupational injury or illness to the insurer, the worker's employer, the worker's representative, and the department. Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim. [281-A:23 V(a)]

New Hampshire Workers' Compensation Medical Form

The N.H. Workers' Compensation Medical Form is to be completed by the treating health-care professional following each visit by an injured employee. While the legal requirement is that the health-care professional complete this form and file it with the workers' compensation insurance carrier within 10 days of treatment, in practice the form is typically completed by the treating health-care professional at the time of treatment.

It is strongly recommended that an employer have the treating health-care provider fax a copy of the medical form to the company offices immediately following any treatment. Additionally it is recommended that any injured employee who is seeking medical treatment for a work-related injury be instructed to return to the employer with his/her copy of the form immediately following medical treatment for the work-related injury.

The N.H. Workers' Compensation Medical Form tracks very nicely with the N.H. Job Task Analysis Form. Since the two forms complement each other, they enable employers and employees to identify the specific temporary alternative duty job tasks that the injured employee can perform.

It is a good idea to have the injured employee and his/her supervisor together review both forms. This helps ensure that the temporary alternative duty job is within the limitations outlined by the treating health-care professional, affords the opportunity to go over possible job modifications that may allow the injured employee to return to his/her regular position, clarifies for the injured employee his/her job responsibilities and finally, makes the supervisor aware of the full extent of the injured employee's work limitations.

NH WORKERS' COMPENSATION TASK ANALYSIS

In compliance with RSA 281-A:23-b, the employer with 5 or more employees must provide temporary alternative/transitional work opportunities to all employees temporarily disabled by a work-related injury or illness.

Task is defined as one of the distinct activities that constitute logical and necessary steps in the performance of a job. A *task analysis*, for the purpose of this section, is the evaluation of the physical requirements of each task of a particular job or work assignment.

Employer_____ Employee_____

Telephone #_____ W.C. Insurer_____

Employer Address_____

Complete the following information to describe the employee's job at the time of injury:

Job Title_____ Usual Job? Yes___ No___ General Description/Purpose_____
_____

Department_____ Supervisor _____
Description of Tasks (use additional page as needed):

1. _____
2. _____
3. _____
4. _____
5. _____

Tools & Equipment_____

Describe Special Demands_____
_____

PHYSICAL DEMANDS

Complete the following to show the *maximum* physical demand for all of the tasks listed above. For example, if Tasks 1 through 4 require no bending but Task #5 requires "occasional" bending, the overall job must be rated as requiring occasional bending.

JOB REQUIRES part of day	Continuous 100%-67%	Frequent 66%-34%	Occasional 33%-1%
bending			
kneeling			
squatting			
climbing			
standing			
walking			
sitting			
reaching			
driving			
fine motor skills			

JOB REQUIRES:

maximum lifting/carrying of _____lbs

frequent lifting/carry of _____lbs

WORK SCHEDULE:

Number of hours/day _____

Number of days/week_____

Does job require Repetitive Motions? (check if applicable)				
	wrist	elbow	shoulder	ankle
Right				
Left				

ATTACH JOB DESCRIPTION IF AVAILABLE

_____ _____ _____
Completed by Title Date

TITLE XXIII
LABOR

CHAPTER 281-A
WORKERS COMPENSATION

Section 281-A:14

281-A:14 Employee's Fault. – The employer shall not be liable for any injury to a worker which is caused in whole or in part by the intoxication, as defined in RSA 281-A:2, XII-a, or by the serious and willful misconduct of the worker. The provision as to intoxication shall not apply, however, if the employer knew that the employee was intoxicated.

Source. 1988, 194:2. 1990, 254:10, eff. Jan. 1, 1991.

Vermont

- First Report of Injury (Form 1)
- Work Capabilities Form (Form 20)
- Frequently Asked Questions about Workers' Compensation by Employees
- Title 21, Section 618 – Compensation for Personal Injury
- Title 21, Section 649 – Injuries Not Covered; Burden of Proof

VERMONT

DEPARTMENT OF LABOR – ATTN: WORKERS' COMPENSATION
5 Green Mountain Drive, PO Box 488
Montpelier, VT 05601-0488

Form 1 (Rev. 7/08)
(Approved for use as OSHA 101 and 301)

State File No. _____

EMPLOYEE'S CLAIM AND EMPLOYER FIRST REPORT OF INJURY

Complete form and send original to the Commissioner of Labor within 72 hours of accident. Send duplicate to your workers' compensation insurance company, give Employee's copy to employee and retain Employer's copy for your files. Answer every question fully and report promptly to avoid a penalty. Employer's Federal ID Number and Employee's Social Security Number MUST be provided.

EMPLOYER

1.Legal Name:	**2.Business Name:**
3. Mail Address: **No. and Street** **City** **State** **Zip**	
4. Location (if different from Mail Address):	**5. Federal ID No.**
6. Nature of Business (list principal products or service of concern):	**7. Do you regularly employ 10 or more employees?** ☐ Yes ☐ No **8. Telephone No.**

EMPLOYEE

9. Name: First Name	**Middle Initial**	**Last Name**	**10. Social Security No.**	**11. Date of birth:**
12. Home Address: No. and Street		**13. Telephone No.**	**14. Job Title:**	**15. Age**
City **State** **Zip**		**16. Dept. assigned to:**		**17. Sex** ☐ M ☐ F
18. Wages $ **Per**	**Hours Per Day** **Days Per Week**	**19. If board, lodging, etc. were furnished in addition to wages, state estimated value:** $	**20. Was employee hired in VT?** ☐ No ☐ Yes	**21. Date of Hire**

ACCIDENT

22. Date of Accident:	**Accident Time** a.m. p.m.	**Began Shift** a.m. p.m.	**23.Machine or tool involved in the accident:**
24. Location of Accident:	**Town or City** **State**	**25. Was it defective?** ☐ No ☐ Yes **If yes, describe how.**	
26.On employer's premises? ☐ No ☐ Yes **If yes, name of dept.:**		**27.Object or substance directly causing injury:**	
28. Describe what employee was doing:		**Was this the employee's regular occupation?** ☐ No ☐ Yes	
29. How did accident occur? Describe events leading up to the accident.			
30. Can the employer prevent this type of accident? ☐ No ☐ Yes **If yes, describe how.**			
31. Was safety equipment, such as goggles or guards, etc. provided? ☐ No ☐ Yes			
32. Could the injured have prevented this type of accident? ☐ No ☐ Yes **If yes, describe how (do not say, "By being more careful.").**			
33. If safety equipment was provided, was it being used? ☐ No ☐ Yes			

INJURY

34. Describe the injury and the part of body injured.			**35. Was this a first-aid only injury: ☐ Yes ☐ No**		
36. Any Lost Time? ☐ No ☐ Yes	**If yes, date disability began.**	**Last date paid in full:**	**37. Employee returned to work?** ☐ No ☐ Yes	**If yes, date returned.**	**At what weekly wage:** $
38.Did injury result in death? ☐ No ☐ Yes	**If yes, date of death.**	**39. If death, name and address of nearest relative.**		**Relationship**	
40. Name and Address of Physician					
41. Name and Address of Hospital			**Remained overnight?** Yes ☐ No ☐		

INSURANCE

42.Workers' Compensation Insurance Carrier. Do NOT give your insurance agent's name.	
Name in full:	**Policy No.**
Signed by:	
Employer or Representative	Title Date

____Provided Form 8 ____ Dept. of Labor ____ Ins. Co. ____Employer ____Employee

Equal Opportunity is the Law

VERMONT

www.labor.vermont.gov

STATE OF VERMONT
DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION
5 GREEN MOUNTAIN DRIVE, PO BOX 488
MONTPELIER, VT 05601-0488
(802) 828-2286

DOL FORM 20 Rev 5/05

State File No. _____
Ins. Co. File No. _____
Date of Injury _____
Fed. ID No. _____
Soc. Sec. No. _____

WORK CAPABILITIES FORM

Form recommended for use by medical providers in assessing work capabilities of patients with work injuries

Employee's Name: _____

Based on my examination of this patient on _____(date)
☐ May **NOT RETURN TO WORK**
☐ May **Return to work** with **no restrictions**
☐ May **Return to work** on _____**with the following capabilities**:

WORK CAPABILITIES – may perform the following:

(a) **Stand/Walk**:
☐ Not at all ☐ 1-3 hrs ☐ 3-5 hrs ☐ 5-8 hrs ☐ Unrestricted

(b) **Sit**:
☐ Not at all ☐ 1-3 hrs ☐ 3-5 hrs ☐ 5-8 hrs ☐ Unrestricted

(c) **Drive**:
☐ Not at all ☐ 1-3 hrs ☐ 3-5 hrs ☐ 5-8 hrs ☐ Unrestricted

(d) **Lift**:
☐ Not at all
☐ No more than 10 lbs. ☐ Occasionally ☐ Frequently ☐ Unrestricted
☐ No more than 20 lbs. ☐ Occasionally ☐ Frequently ☐ Unrestricted
☐ No more than 50 lbs. ☐ Occasionally ☐ Frequently ☐ Unrestricted
☐ No more than 100 lbs. ☐ Occasionally ☐ Frequently ☐ Unrestricted
☐ Unrestricted

(e) **Bend**:
☐ Not at all ☐ Occasionally ☐ Frequently ☐ Unrestricted

(f) **Squat**:
☐ Not at all ☐ Occasionally ☐ Frequently ☐ Unrestricted

(g) **Climb**:
☐ Not at all ☐ Occasionally ☐ Frequently ☐ Unrestricted

(h) **Twist**:
☐ Not at all ☐ Occasionally ☐ Frequently ☐ Unrestricted

(i) **Reach above shoulders**:
☐ Not at all ☐ Occasionally ☐ Frequently ☐ Unrestricted

Specific work capabilities not listed above:_____.
Employee has limited use of: _____.

Employee ☐ can ☐ cannot perform repetitive activities ☐ for more than _____ min/hrs.
Employee ☐ can ☐ cannot work more than 8 hours a day.

☐ Work capabilities are in effect ☐ until _____;or ☐ until further evaluation:

☐ Scheduled for follow-up appointment on _____.

☐ Referred to _____ for follow-up care.

If disabled at this time, estimate duration of total disability:_____.

Comments: _____

_____

_____ _____
Medical Provider's Name (Print) Date

_____ _____
Medical Providers Signature

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize this Medical Provider to release any information acquired in the course of my examination or treatment for the above injury to my employer or its representative.

Patient Signature: _____Date: _____

Vermont Department of Labor & Industry

Workers' Compensation Division

Frequently Asked Questions

Q: What are covered medical benefits?

A: Workers' compensation provides coverage for all reasonably necessary medical services and supplies related to an on-the-job injury. In appropriate cases, this may include not only coverage for doctors visits and hospital treatment, but also coverage for physical therapy, medication, chiropractic treatment and psychological counseling.

Q: Do I need a lawyer?

A: That depends upon the complexity of the claim. Discuss it with the Workers' Compensation Division if you are in doubt.

Q: What is temporary disability?

A: If you are unable to work at all during your recovery from a work-related injury, then you will be provided with weekly wage replacement compensation, called temporary, total disability compensation. In addition you will be provided with a small supplement for each of your dependent children. If your doctor releases you to part-time work or light duty work while you are recovering, then you may be entitled to temporary, partial disability compensation.

Q: What is permanent impairment compensation?

A: If you are left with a permanent impairment following your recovery, you may receive additional compensation (related to loss of function) once your temporary disability compensation ends. The law provides a schedule from which these benefits are calculated.

Q: Is there a list of physicians who perform permanent partial impairment evaluations?

A: Yes. Please click here for a list of physicians in the State of Vermont.

Q: Do I have a right to get my old job back?

A: If your employer has 10 or more employees, and if you recover from your injury within 2 years, you have a right to be reinstated in the next available, suitable job. This means that if your employer has hired someone to take your place, you cannot insist that the person be fired; however, the next available position that is appropriate, given both your job qualifications, and your physical capacity, must be first offered to you. You must keep your employer informed of your availability and willingness to return to work.

Q: What if I am unable to return to my pre-injury job as a result of my injury?

A: You should begin looking for work within the physical restrictions set by your treating physician. You may be entitled to vocational rehabilitation assistance to help you find suitable alternative employment. The goal of this assistance is to ensure that you return to work in a job that is both safe, given your physical capacities, and appropriate to your educational and employment background.

Q: How do I get Workers' Compensation?

A: You should notify your employer as soon as possible after you have been injured on the job. Your employer then has 72 hours to report it to the Workers' Compensation Division. At the same time,

your employer's insurance adjuster is notified and has 21 days to investigate and to decide whether or not to accept your claim.

Q: What should I do if I am released to return to work?

A: If your doctor releases you to return to work, either full or part-time, you should contact your employer immediately to see if an appropriate position, suitable to your condition, is available for you. If it is, you are obligated to take it or risk losing your right to further compensation and/or vocational rehabilitation assistance. If there is no suitable job available, you may be entitled to continued compensation. If the return to work is part-time, you are entitled to temporary, partial disability compensation.

Q: What do I do if my employer has failed to file a claim?

A: Contact the Workers' Compensation Division at (802) 828-2286.

Q: What if my claim is denied?

A: If your employer's insurance adjuster notifies you that it has denied your claim or that it disputes your right to further compensation or medical benefits, you have a right to contest that decision before the Workers' Compensation Division.

Q: How does the Workers' Compensation Division deal with claims?

A: Specialists work closely with the insurance claims adjuster and claimant. They will see that the adjuster completes the necessary paperwork and insure that medical examinations are performed as required. These specialists may also serve as mediators, helping the parties resolve conflicts over case issues. Further, they act in a regulatory capacity and may issue interim orders when a carrier disagrees with the Division's interpretation of the statute.

Q: How many of the claims that the Workers' Compensation Division receives require hearings?

A: In fiscal year 1994, of the over 25,000 First Reports of Injury, about 9,300 involved some intervention by the Workers' Compensation Division. Of these, about 1,500 requested a hearing and about 100 of these required adjudication and a decision by the Commissioner. A party that is dissatisfied with a hearing decision has further recourse to the Superior and Supreme Courts.

Q: What if I have additional questions concerning workers' compensation?

A: Contact the Workers' Compensation Division at the Vermont Department of Labor. We will try to provide you with the information you need.

Q: What is the penalty for making a false statement or representation or for refusing or neglecting to comply with an order or rule or regulation?

A: A person who willfully makes a false statement or representation for the purpose of obtaining any benefit or payment may be assessed an administrative penalty of not more than $1,000 and shall forfeit all or a portion of any right to compensation. An employer who makes a false statement for the purpose of obtaining a lower workers' compensation premium, or who refuses to comply with rules and regulations, may be assessed an administrative penalty of not more than $5,000 (21 V.S.A. §§687, 688, 708).

The Vermont Statutes Online

Title 21: Labor

Chapter 9: Employer's Liability and Workers' Compensation

618. Compensation for personal injury

§ 618. Compensation for personal injury

(a)(1) If a worker receives a personal injury by accident arising out of and in the course of employment by an employer subject to this chapter, the employer or the insurance carrier shall pay compensation in the amounts and to the person hereinafter specified. The compensation of a person who is under guardianship shall be paid to the person's guardian.

(2) If the injury occurred while engaged off the premises of the employer in a recreational activity that is available to the employee as part of the employee's compensation package or as an inducement to attract employees, it shall not be considered to have occurred in the course of employment unless the commissioner finds at least one of the following:

(A) The employer derived substantial benefit from the activity, beyond that of attracting labor or improving employee health and morale.

(B) The activity was reasonably part of the employee's regular duties or undertaken to meet the expectations of the employer.

(C) The activity was undertaken at the request of the employer.

(3) [Deleted.]

(b) A worker who receives a personal injury by accident arising out of and in the course of employment with an employer who has failed to comply with section 687 of this title may elect to claim compensation under this chapter or to bring a civil action against the employer for full damages resulting from the work injury. In the civil action the employer has the burden of proving that the injury did not result from the employer's negligence and that the employer's negligence was not the proximate cause of the injury. The employer may not plead as a defense any of the following:

(1) The injury was caused by the negligence of a fellow-employee.

(2) The defense provided under 12 V.S.A. § 1036 unless the negligence was willful and with the intent of causing an injury.

(3) The employee assumed any risk in the employment.

(c) A worker shall commence a civil action under subsection (b) of this section within the three-year limitation period as provided in 12 V.S.A. § 512(4).

(d) The acceptance of any payment by an employee for a work injury shall not bar a subsequent election to pursue a civil suit under subsection (b) of this section unless the employee, with knowledge of his or her rights, signs a written agreement waiving the right to pursue a civil action. The agreement shall be filed with and approved by the commissioner. If the employer fails to pay any amount due and owing under the workers' compensation act the waiver agreement shall be void and the employee may pursue a civil action.

(e) Any employee who prevails in a civil action under subsection (b) of this section shall be entitled to costs, interest from the date of filing the claim and reasonable attorneys' fees. (Amended 1981, No. 165 (Adj. Sess.), § 1; 1997, No. 19, § 1; 1997, No. 59, § 34a, eff. June 30, 1997; 1999, No. 85 (Adj. Sess.), § 2, eff. April 19, 2000; 2003, No. 132 (Adj. Sess.), § 9, eff. May 26, 2004.)

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§ 649. Injuries not covered; burden of proof

Compensation shall not be allowed for an injury caused by an employee's wilful intention to injure himself or another or by or during his intoxication or by an employee's failure to use a safety appliance provided for his use. The burden of proof shall be upon the employer if he claims the benefit of the provisions of this section.