



EARLY RETURN TO WORK (ERTW)
== TOOLBOX ==
FOR EMPLOYERS AND SUPERVISORS

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DEFINITIONS OF DIFFERENT TYPES OF WORK

Graduated return-to-work (Part-time Work) - The health care provider authorizes gradual increases in the hours worked and the tasks performed.

Transitional return-to-work - A temporary job where the worker is expected to be able to go back to the job of injury during early intervention.

Light-duty work - Temporary work that is less vigorous and fits the provider's restrictions.

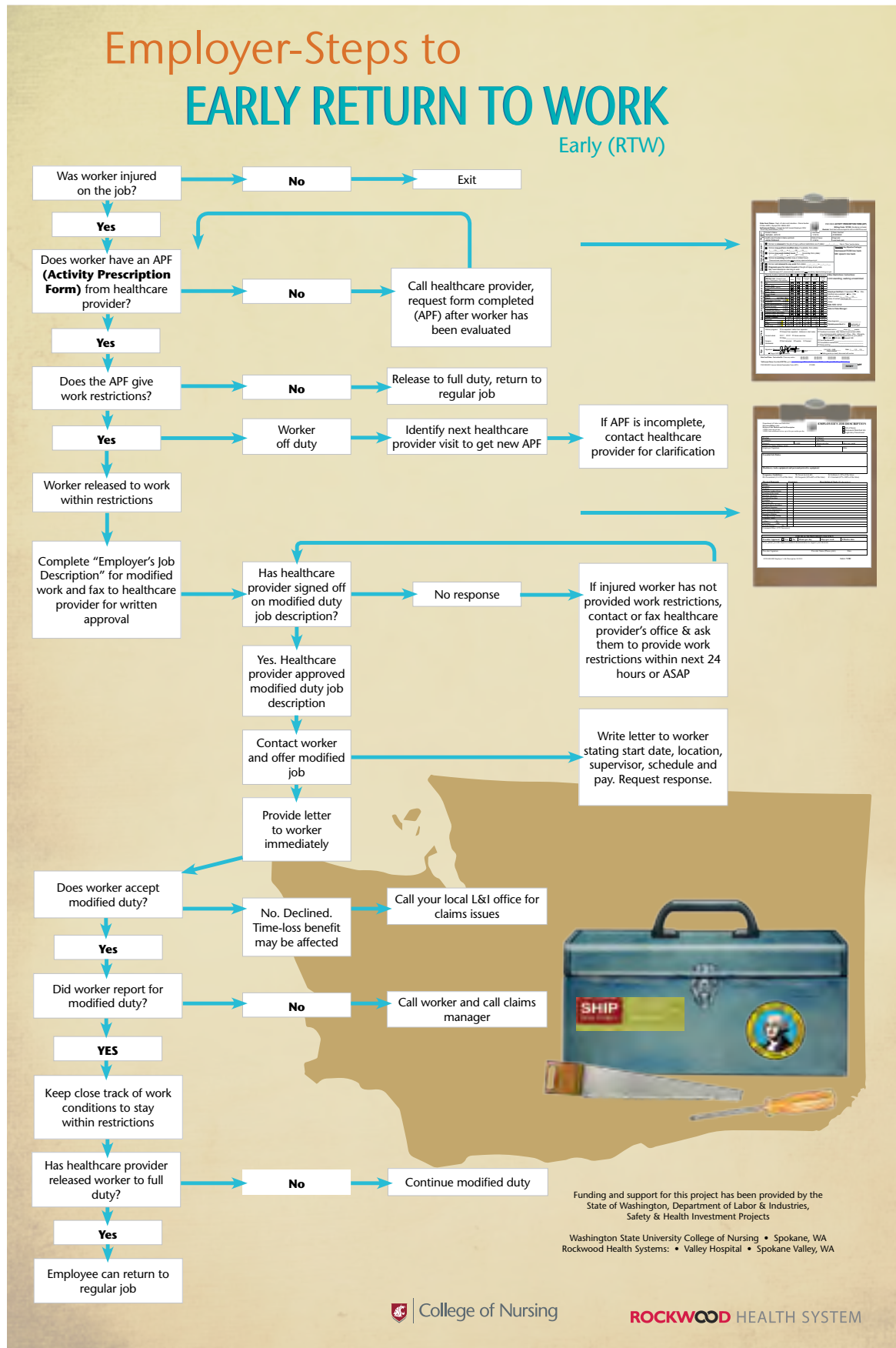
Modified work - A change in the way the job is normally done to stay within the employee's physical restrictions.

<http://www.lni.wa.gov/IPUB/200-003-000.pdf> p7

Temporary work - A job that is not ongoing.

Alternative work - A different job in the company that meets the employee's physical restrictions. It can be an existing job, or a set of job tasks that you need done.





INTRODUCTION TO EARLY RETURN TO WORK (ERTW)

In today's business culture, if an employee is injured on the job, the goal is to quickly and successfully return the employee back to work during the recovery and the rehabilitation phase.

a) *How does ERTW benefit the employer?*

ERTW embraces health and safety awareness in the workplace and decreases costs in time loss, medical expenses, and insurance premiums. **By letting your worker return to work with restrictions, you gain in the following ways:**

1. Labor and Industries may reimburse 50% of the salary of the ERTW worker
2. Your injured employee provides useful labor while working in ERTW
3. Your injury statistics improve and that saves your company work compensation insurance premiums
4. It enhances transparency among supervisors, injured workers and their co-workers

b) *How does ERTW benefit the injured worker?*

Injured workers may worry about the future and losing their job. By returning to work early with work restrictions the workers gain the following benefits:

1. They feel needed and reassured
2. They typically retain their usual wages
3. They maintain their level of physical fitness to do the job by coming in to work regularly
4. They retain their self-image of being a productive employee
5. The worker's stress is reduced

c) *How does Labor and Industries benefit from employers implementing the ERTW program?*

Labor and Industries, as the workers' compensation insurance company for the State of Washington, has researched the benefits of Early Return to Work (ERTW). These studies show that injured workers who are out of work for even a few months are significantly less likely to return to work. This makes for very expensive claims. The State of Washington prefers to keep employer workers' compensation rates as low as possible.

One strategy is to encourage Early Return to Work.

Map of Washington State L&I Regions



a) *When to train employees about ERTW*

It is best to establish a culture of ERTW from the first day of employment. Include a short training video or presentation on ERTW as a part of your company's philosophy at new employee orientation. Even small companies can include a short ERTW orientation. Every worker should learn to report an on-the-job injury right away to the supervisor.

For existing employees, a company-wide video or computer module on the ERTW benefit is a good way to introduce the ERTW concept during annual training.

b) *When to use ERTW?*

ERTW is for all employees who incur an on-the-job injury. It is not for people who are injured while off duty. Injured workers are entitled to a host of benefits, including ERTW. A worker is eligible to return-to-work when the health care provider releases him or her to modified or light duty. This may be the same day as the injury or the next day.

c) *Who manages ERTW?*

Each company should select an ERTW specialist. It may be the owner in a small company, the human resources specialist or workers' compensation specialist in a medium-sized company. In some circumstances, it may be an occupational or physical therapist or the occupational health nurse. It is their job to ensure the paperwork is completed and help supervisors determine what modified tasks are appropriate given the work restrictions. The responsible person also monitors the ERTW program to help workers stay within their prescribed work restrictions.

d) *Who pays for ERTW?*

To encourage Early Return to Work, the State of Washington may pay 50% of the worker's salary. ERTW workers typically remain in their home cost centers. However, some companies will create a separate fund using corporate overhead or place the worker in the human resources cost center. It is important to remember the employer is saving money by getting the worker back to work quickly, ideally within three days of injury. As stated, Labor and Industries may pay **half** the worker's salary, up to 66 days or \$10,000, as an incentive for

employers to take injured workers back to work in the ERTW/Stay at Work program.

Washington Stay at Work: In 2011, the Washington Legislature voted to create a Stay at Work program: “*Stay at work is a new financial incentive that helps employers keep injured workers on the job or bring them back to work quickly and safely back to light-duty or transitional work by reimbursing them for a portion of the costs.*”

(Washington State Department of Labor & Industries: Employer’s Return-to-work Guide. pg. 9). *The Complete Stay at Work Guide for Employers offers instructions for reimbursement.*

<http://www.lni.wa.gov/IPUB/200-003-000.pdf>

What is the ERTW process?

A successful ERTW program begins with management writing supportive policies and procedures. [The ERTW Flow Chart from Chapter 2 of this ToolBox](#) shows the steps that an employer needs to take. Here is a short summary of the ERTW Flow Chart that presents the three main components of the ERTW process.

First, the employer receives an **Activity Prescription Form--APF** (or similar form) from the health care provider. The employer then immediately considers the restrictions and the job tasks that are available. **Second**, when the employer has identified tasks for the worker to do within restrictions, the employer fills out the **Employer’s Job Description form** and faxes it to the health care provider right away. **Third**, after approval and signature by the health care provider, the employer offers the modified duty job to the injured worker who then either accepts or declines the offer. A worker can refuse to participate in ERTW, but that worker may lose his or her workers’ compensation time loss pay. Even if the worker declines ERTW, he or she continues to be eligible for injury-related medical care.

f) When does ERTW stop?

ERTW stops when the health care provider releases the worker back to full duty. An employer typically sets a time limit on the length of ERTW because the job is by definition temporary.

TROUBLE-SHOOTING ERTW

Sometimes getting a worker back to work in the real world seems very complicated. Here are some tips on solving problems before they happen.

a) *What to do when no light duty work is available*

This is a frequent first thought by employers. It may be true that you have no jobs that fit the work restrictions, but there are always tasks *within* jobs that fit the restrictions. Think about the bits and pieces that make up the job as a whole. Among those bits and pieces there usually will be tasks that are within the worker's restrictions. There are several examples in this ToolBox for you to consider and a list just below.

b) *Challenges with accommodating workers*

Sometimes injured workers think they automatically get paid time off when they get hurt. Or, it may be that workers have fears of returning to work. Always talk to your worker to determine the worker's concerns.

If the injured worker is unavailable by phone or seems reluctant, you may write the worker a certified letter offering the approved ERTW job. Give him or her a reasonable time to respond and report for work. There are specific facts that are necessary in this letter, see the examples in this ToolBox. Send a copy of the letter to your claims manager by fax.

c) *Communicating with health care providers*

A short phone call with the health care provider can oftentimes resolve ERTW issues. As an employer, you are welcome to call the health care provider about your injured worker. You can also find information about your employee's medical progress on L&I's Claims and Account Center website. HIPPA medical privacy laws do not apply to employers for worker's compensation cases.

You can read the latest work-related medical reports about your worker online at

<http://www.lni.wa.gov/ORLI/LoGon.asp> (RCW 51.36.060)

d) *Health care provider not releasing the worker back to full duty*

Rarely, a health care provider may seem slow to release an injured worker back to full duty. The health care provider should be regularly physically checking the injured worker's condition and increasing physical capabilities, typically about every two weeks. If the new Activity Prescription Form is identical to the last one, call the provider and the claims manager to encourage progress. If lack of progress persists, the claims manager may take other actions to help move the claim along.

e) *Opportunities to develop cooperative relationships with Labor and Industries*

If you feel the injury may not be valid, contact your claims manager to discuss the specifics of the situation. Labor and Industries is available for your ERTW needs. Try calling your local L&I office or going in and explaining your needs. L&I has experts in ERTW who can provide guidance if you encounter an obstacle.



f. Suggestions for Modified Job Tasks

JOBS CATEGORY	TASKS INVOLVED
Clerical Support	<ul style="list-style-type: none"> • Answer phones in office • Customer service • File paperwork • General errand running • Greeter • Organize equipment • Restock shelves • Safety monitor • Shredder/sorter • Log in data • Organize files • Give training or safety classes • Special projects • Replenish supplies in all areas • Create staffing schedules
Clinical Assignments	<ul style="list-style-type: none"> • Vital signs • Patient admissions • Patient interviews • Medication administration • IV administration • Assist Infection Control • Assist Employee Health with files & records • New employee orientation • Review standards & policies • Data entry • Update bulletin boards • Assist with unit performance improvement projects • Telephone patients for appointments & follow-up • Take minutes in staff meetings • Train employees in using new equipment

JOBS CATEGORY**TASKS INVOLVED**

Clinical Assignments

- Conduct tours
- Teach classes to staff or patients
- Provide intermittent relief for clerical staff during breaks and lunch
- Make charts
- Verify insurance coverage
- Keep work areas organized
- Feed patients
- Assist pharmacy with labeling, stocking inventory & organizing

Janitorial & Grounds-keeping Assignments

- Assist with ordering supplies
- Reviewing & updating procedures
- New employee orientation
- Assist with staffing schedules
- Assist with logging & stocking supplies
- Monitor facilities in need of services
- Observing & documenting areas needing janitorial attention.
- Greeting visitors & clients
- Replenish restroom supplies

Security Assignments

- Taking & making phone calls
- Prepare reports
- Orienting new employees
- Filing & computer tasks
- Ordering equipment & supplies
- Review disaster & emergency response preparedness plans
- Greeting visitors & clients
- Inventory and order supplies
- Orienting new employees
- Reviewing policies and procedures
- Receiving phone calls
- Filing & computer work
- Monitor hygiene practices
- Review recipes
- Review vendor sales

**This list provides a few examples. It is not considered all inclusive. Remember that you can examine the specific job description of the worker to evaluate which job or task components the worker can safely perform within the restrictions outlined by the health care provider. Develop relationships with other departments, sections, or units within the organization and discuss sharing the injured worker who may be able to perform tasks outside his or her assigned department.

FORMS FOR ERTW

a) Report of accident:

When an injured worker has seen a health care provider, the employee and health care provider complete the **REPORT OF ACCIDENT** form.

Here is an example of that form. It can be completed online if the employer is signed up through the Claims and Account Center (CAC).
Go to: <http://www.lni.wa.gov/ORLI/LoGon.asp>

The form is titled "Report of Accident (Workplace Injury, Accident or Occupational Disease)" and includes a date stamp "Jul 12, 2015 3:37PM" and a form number "AV 56596". It is divided into four main sections:

- Worker Information:** Includes fields for name, address, date of birth, sex, height, weight, and date of injury. It also asks for details about the injury and whether it was due to a specific incident.
- Family and dependent eligibility:** Asks for family status (married, divorced, etc.) and dependent eligibility for children and other dependents.
- Employer Information:** Includes fields for business name, address, type of business, and employee details like pay rate and work schedule.
- Health Care Provider Information:** Includes fields for the provider's name, address, and details about the medical treatment received.

A large 'X' is marked in the bottom right corner of the form, indicating it is a copy.

b. Activity Prescription Form (APF):

This is the form the health care provider will fill out stating what the worker can safely do. Providers or employers may have their own specific forms but the basics of the information required are the same. There is a blank form and then three sample forms.

1. Blank APF

Find this form at:

<http://www.lni.wa.gov/ClaimsIns/Providers/Claims/ActivityRx/>

State Fund Claims: Dept. of Labor and Industries (L&I) (2008) Revision
 P.O. Box 44231, Olympia, WA 98544-4231

Self-Insured Claims: Certified Self-Insured Employer (SIE)
 1988 Family Administration (FPA)

INSURER ACTIVITY PRESCRIPTION FORM (APF)
 Billing Code: 1072M (Continued on back)
 Reminder: Print clear name and number in all or in 3072M for use

Worker's Name: _____ YPO Date: _____ Claim Number: _____
 Health-care Provider's Name (printed): _____ Date of Injury: _____ Diagnosis: _____

Medical Release for work?
 Worker is released to the job of injury without restrictions as of (date) _____ Day is "Y" for work back.
 Worker may perform modified duty, if available, from (date) _____
 Worker may work limited hours _____ hours/day from (date) _____
 Worker is working modified duty or limited hours:
 Please attach capacities below and attach any release orders if any.
 Worker is not released to any work from (date) _____ to _____
 Prognosis poor for return to work at the job of injury at any date.
 May need assistance returning to work.
 (Prognosis App. 107, please submit separate form app. provided by medical provider at job)

Required: Key Objective Findings:

Capacity duration (estimate days): 1-10 11-20 21-30 31+ permanent

Worker can: (Please check one)
 (Yes) (No) (Not Applicable) (Not Specified)
 Sit _____
 Stand / Walk _____
 Climb (ladder / stairs) _____
 Twist _____
 Bend / Squat _____
 Push / Pull _____
 Carry _____
 Reach Left, Right, Back _____
 Lift (weight frequency) L, R, B _____
 Hoist/Lift L, R, B _____
 Throw (frequency/distance) L, R, B _____
 Grasp (frequency) L, R, B _____
 Vise manipulation L, R, B _____
 Operate tool/equipment L, R, B _____
 Vibrate tool, high impact _____
 Operate other tool/equipment _____

Other Restrictions / Instructions:

Employer Notified of Capabilities? (Yes/No)
 Modified duty available? Yes No
 Date of contact: _____
 Name of contact: _____
 Address: _____

Notes to Claim Manager:

Other Restrictions:

Options provided to: Active patient Discontinue

Required: Plans:
 Worker progress: As expected / better than expected
 Slower than expected, discuss in next visit
 Clinical notes: PT OT Home exercise
 Other _____
 Surgery: Not indicated Possible Planned
 Comments: _____
 Next scheduled call in _____ days _____ weeks
 Treatment (physical, MDT, Manual manipulation (MM))
 Any permanent partial impairment? Yes No Pending
 If yes are additional, please rate impairment for visit period:
 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
 Care transferred to: _____
 Consultant needed with: _____
 Sily pending: _____

Sign: Signature (Required) _____ Date: _____
 Provider (S/AN/P) NP-C
 Copy of APF given to worker Taking parts (printed) discussed with worker

State Fund Claims: Fax to John De. (Cover any orders): 800-824-2271 360-424-4886 360-424-4180 360-424-4181
 800-824-2272 360-424-4170 360-424-4200 360-424-4480

*Self-Insured Claims: For a list of SIE/PAs go to: www.lni.wa.gov/ClaimsIns/Providers/Claims/ActivityRx/

3043-045-200 (Insurer Activity Prescription Form (APF)) 08-2009 **APF**

2. Example APF for back injury

State Fund Claims: Dept. of Labor and Industries - Claims Section
PO Box 44291, Olympia WA 98504-4291

Self-Insured Claims: Contact the Self Insured Employer (SIE)
Third Party Administrator (TPA)*

INSURER ACTIVITY PRESCRIPTION FORM (APF)

Billing Code: 1073M (Guidance on back)
Reminder: Send chart notes and reports to L&I or to SIE/TPA as usual.

General Info	Worker's Name: Janet Doughly	Visit Date: 5/15/14	Claim Number: AJ528301
	Health-care Provider's Name (printed): Jamie DoGood	Date of Injury: 5/15/14	Diagnosis: Sprain L wrist and elbow

Required: Released for work? Check at least one

Worker is **released** to the job of injury without restrictions as of (date): ___/___/___ Skip to "Plans" section below.

Worker **may perform modified duty**, if available, from (date):
5 / 16 / 14 to 5 / 29 / 14

Worker **may work limited hours**. ___ hours/day from (date):
___/___/___ to ___/___/___

Worker is **working modified duty** or limited hours
Please estimate capacities below and provide key objective findings at right.

Worker **not released to any work** from (date): ___/___/___ to ___/___/___

Prognosis poor for return to work at the job of injury at any date

May need assistance returning to work
Capacities apply 247, please estimate capacities below and provide key objective findings at right.

Required: Key Objective Finding(s)

Limited ROM L wr and elbow
Swelling L wr and elbow
Decreased grip strength L hand

Capacity duration (estimate days): 1-10 11-20 21-30 30+ permanent

Worker can: (related to work injury.) Blank space = Not restricted	Never	Seldom 5-10% 0-1 hour	Occasional 11-20% 1-2 hours	Frequent 34-60% 3-4 hours	Constant 67-100% Not restricted
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand / Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb (ladder / stairs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend / Sloop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat / Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keyboard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist (flexion/extension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasp (forceful)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate foot controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vibratory tasks: high impact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vibratory tasks: low impact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Restrictions / Instructions:

No ladders. No use Left arm
****OK use R arm****

Employer Notified of Capacities? Yes No
Modified duty available? Yes No
Date of contact: 5 / 15 / 14
Name of contact: Gail Knight, RN
Notes:
EOI has LD avail. IW to RTW 5/16/14

Note to Claim Manager:

New diagnosis: _____

Opioids prescribed for: Acute pain or Chronic pain

Required: Plans

Worker progress: As expected / better than expected.
 Slower than expected. Address in chart notes

Current rehab: PT OT Home exercise
 Other: _____

Surgery: Not indicated Possible Planned

Comments: _____

Next scheduled visit in: 14 ___ days, ___ weeks.
 Treatment concluded, Max. Medical Improvement (MMI)
Any permanent partial impairment? Yes No Possibly
If you are qualified, please rate impairment for your patient.
 Will rate Will refer Request IME

Care transferred to: _____
 Consultation needed with: _____
 Study pending: _____

Sign Signature (Required): _____ (98) 555 - 1234 Date: 05 / 15 / 14
Phone number: _____
 Doctor ARNP PA/C
 Copy of APF given to worker Taking points (on back) discussed with worker

State Fund Claims: Fax to claim file. Choose any number: 360-903-4292 360-903-4545 360-903-4566 360-903-4517
360-903-5230 360-903-4100 360-903-4252 360-903-4480

*Self Insured Claims: For a list of SIE/TPAs, go to: www.Lni.wa.gov/Claims/Insurance/Reinsurance/Employer/FindEmployer.asp

F242-385-000 Insurer Activity Prescription Form (APF) 07-2009

RESET APF

3. Example for hand and arm injury

State Fund Claims: Dept. of Labor and Industries - Claims Section
 PO Box 4039, Olympia WA 98504-0391
 Self-Insured Claims: Contact the Self-Insured Employer (SIE)
 Third Party Administrator (TPA)*

INSURED ACTIVITY PRESCRIPTION FORM (APF)
 Billing Code: 1073M (Customer use back)
 Worksheet: Send claim notes and reports to L&I or to TPA (if used)

General Info

Workers Name: **Janel Doughty** Your Date: **5/15/14** Claim Number: **AJ528391**
 Height/eye Provider's Name (printed): **Jamie DeGood** Date of Injury: **5/15/14** Diagnosis: **Sprain L wrist and elbow**

Required: Released for work? (Check at least one)

Worker is released to the job of injury without restrictions as of (date) ____/____/____. Skip to "Other" section below.
 Worker may perform modified duty, if available, from (date) **5/15/14** to **5/25/14**.
 Worker may work limited hours _____ hours/day from (date) ____/____/____ to ____/____/____.
 Worker is working modified duty or limited hours. (Please estimate number below job period for objective findings of report.)
 Worker not released to any work from (date) ____/____/____.
 Prognosis poor for return to work as the job of injury at any date.
 May need assistance returning to work.
Questions about 247, please estimate capacities below and provide any objective findings of report.

Required: Estimate what the worker can do (Unless released to job)

Capacity duration (estimate in days): 1-15 11-25 21-30 30+ permanent

Worker can:	Never	Rarely	Seldom	Frequently	Constantly
Sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand / Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb / ladder / stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend / stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat / Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keyboard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Write (handwritten)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasp (objects)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate foot controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vibratory tasks, high impact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasonic tasks, low impact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Lifting / Pushing

	Never	Rarely	Seldom	Frequently	Constantly
Example	0 lbs	20 lbs	50 lbs	100 lbs	200 lbs
Lift L, R, B	0 lbs	50 lbs	50 lbs	50 lbs	50 lbs
Carry L, R, B	0 lbs	50 lbs	50 lbs	50 lbs	50 lbs
Push / Pull L, R, B	0 lbs	50 lbs	50 lbs	50 lbs	50 lbs

Other restrictions / Instructions:
 No ladders. No use Left arm
 ****OK use R arm****

Employer Notified of Capacities? Yes No
 Modified job available? Yes No
 Date of contact: **5/15/14**
 Name of contact: **Don Wright, RN**
 Address: _____
 EOI has LD avail. IW to RTW **5/15/14**

Note to Claim Manager:

How diagnosed: _____
Options prescribed for: Acute pain rx Chronic pain

Assessed: Plans

Worker progress: As expected / better than expected
 Slower than expected. Address in chart notes

Current status: PT OT Home exercise
 Other: _____

Emergency: Not indicated Possible Planned

Comments: _____

Next appointment visit in: **14** days _____ weeks
 Treating concluded. Max. Medical Improvement (MMI)
 Any permanent partial impairment? Yes No Possibly
 If you are qualified, please rate impairment on your claim.
 Will rate Will refer Request MMI

Care is provided by _____
 Consultation needed with _____
 Study pending _____

Sign

Signature (Required): _____ (S&S) 365-1254 Date: **05/15/14**
 Doctor APRN NAC
Model number:

Copy of APF given to worker Talking points (on back) discussed with worker

State Fund Claims: Fax to claim file. Check any system: 360-903-4282 360-903-4566 360-903-4646 360-903-4647
 800-903-5230 360-903-4100 360-903-4200 360-903-4446

*Self-Insured Claims: Fax to claim file. www.lni.wa.gov/claims www.lni.wa.gov/claims www.lni.wa.gov/claims www.lni.wa.gov/claims

1343-562-002 Insured Activity Prescription Form (APF) 07-2008

RESET APF

4. Example for knee injury

State Fund Claims: Dept. of Labor and Industries - Claims Center
 PO Box 40391, Olympia WA 98546-0391
 Self-Insured Claims: Contact the Self-Insured Employer (SIE)
 Third Party Administrator (TPA)*

INJURY ACTIVITY PRESCRIPTION FORM (APF)
 Billing Code: 1073M (Directions on back)
 Review and check fields and reports in LRS and DCFPA as case

General info
 Worker's Name: Susan Key
 Health-care Provider's Name (printed): Jamie DeGood
 Visit Date: 7/14/14
 Date of Injury: 7/14/14
 Claim Number: Y7309157
 Diagnosis: Fr R little toe proximal

Required: Released for work?
 Worker is released to the job of injury without restrictions as of (date) ___/___/___ Skip to "Plan" section below
 Worker may perform modified duty, if available, from (date) 7/14/14 to 8/04/14
 Worker may work limited hours: _____ hours/day from (date) ___/___/___ to ___/___/___
 Worker is working modified duty or limited hours
Please describe activities below and avoid key objective findings report.
 Worker not released to any work from (date) 7/14/14 to 7/15/14
 Prognosis poor for return to work at the job of injury at any date
 May need assistance returning to work
Capacities (July 2017, please address capacities before and provide key objective findings if null)

Required: Key Objective Findings
 X ray confirmation fr
 Swelling over fr site
 Palpation
 Limited weight bearing

Required: Estimate what the worker can do
Unless annotated by JCR
 Capacity duration (estimate days): 1-10 11-20 21-30 30+ unlimited

Worker can (based on own injury) State (code) + task expected	None	Minimal	Some	Consider	Unlimited
Stc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand / Walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comp. ladder / stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tie	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend / Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squat / Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach					
Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work above shoulders					
L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knob-turn					
L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist (lower extremities)					
L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasp handle					
L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine manipulation					
L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate foot controls					
L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voluntary tasks, high impact					
Voluntary tasks, low impact					
Lifting / Pushing					
Frequency					
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
80 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
90 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100 lbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L, R, B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Restrictions / Instructions:
 Use knee walker for standing and walking. Foot up chair height 10 min/hr.
 Employer Notified of Capacities? Yes No
 Must be fully available? Yes No
 Date of contact: 07/14/14
 Name of contact: Gail Knight, RN
 Note to Claim Manager:
 New diagnosis:
 Capabilities prescribed for: Acute pain or chronic pain

Required: Plans
 Worker progress: All expected / better than expected
 Slower than expected. Address in D&MT / SRS
 Control rehab: PT OT Home exercise
 Other _____
 Surgery: Not indicated Possible Planned
 Comments:
 Next scheduled visit in: 21 days, _____ weeks
 Treatment concluded, Max. Medical Improvement (MMI)
 Any permanent partial impairment? Yes No Possibly
 If you are qualified, please rate impairment for your patient:
 Will not Will rate Request IMC
 Care transferred to: _____
 Consultation needed with: _____
 Study pending

Sign
 Signature (Required): _____ (05) 555-1234 Date: 07/14/14
 Doctor APRN PA-C
Copy of APF given to worker Talking points on SRS discussed with worker

State Fund Claims: Fax or deliver to: Claims center: 509-403-4001 509-403-4000 206-402-4000 206-403-4001
 800-407-5228 206-402-1100 206-402-4200 800-402-4401
 *Self-Insured Claims: For a list of SRS/TPAs go to: www.lni.wa.gov/claims/tpas/for-claims-with-a-self-insured-employer.aspx
 (509) 505-0000 Injury Activity Prescription Form (APF) 05/2009 **RESET APF**

5. *Tips about the APF form*

The backside of the APF form has instructions to the health care provider on how to fill out the form and what specifically is required. Here is a copy.

<p>To be paid for this form, health-care providers must:</p> <ol style="list-style-type: none"> Submit this form: <ul style="list-style-type: none"> With reports of accident when there are work related physical restrictions Complete all relevant sections of the form. Send chart notes and reports, as usual. <p>OR</p> <ul style="list-style-type: none"> When requested by the insurer. 	<p>Important notes</p> <ul style="list-style-type: none"> Use this form to communicate work status, activity restrictions, and treatment plans. This form will also certify time-loss compensation, if appropriate. Occupational and physical therapists, office staff, and others will not be paid for working on this form. To learn how to complete this form, go to www.activityRX.Lni.wa.gov
<p>About impairment ratings</p> <p>We encourage you, the qualified attending health-care provider, to rate your patient's permanent impairment. If this claim is ready to close, please examine the worker and send a rating report.</p> <p>Qualified attending health-care providers include doctors currently licensed in medicine and surgery (including osteopathic and podiatric) or dentistry, and chiropractors who are department-approved examiners.</p> <p>Suggestions for talking with injured workers</p> <p>Research shows that returning to normal activity as soon as safely possible after injury reduces the likelihood of long-term disability. Helping your patients develop expectations and goals for returning to work can improve their outcomes while protecting their incomes and benefits.</p> <p>Here are some conversations that occupational injury and disease specialists recommend you have with your patients:</p> <ul style="list-style-type: none"> "Activity helps you recover." Explain that returning to some level of work and activity will help patients recover from common injuries faster than prolonged bed rest. Be sure patients understand the level of activity they can do at home and work. Emphasize what they can do. "Some discomfort is normal when returning to activities after an injury." Discomfort from activity is different from pain that indicates a serious problem or setback. "You can help with your own recovery." Make sure your patients understand that while you can help with pain and healing, they play an equally important role by following your instructions. "You can protect yourself from re-injury." When musculoskeletal injuries are involved, talk to patients about how changes in the way they move or do their jobs can prevent other injuries. "Early and safe return to work makes sense." The longer you are off work, the harder it is to get back to your original job and wages. Even a short time off work takes money out of your pocket because time-loss benefits do not pay your full wage. <p>To review related research, go to www.Lni.wa.gov and type in "Bibliographies" in the search box.</p> <p style="text-align: center;">Thank you for treating this injured worker.</p>	

If the APF is not filled out completely, fax it immediately back to the health care provider with an urgent note to please complete it so you can better accommodate the injured worker. The form should be filled out anew every time the worker sees the doctor; read the form closely to see what changes and improvements have occurred. You can find this form online shortly after the worker has seen the doctor at the Claims and Account Center.

3. Example of housekeeping job (arm injury)

Department of Labor and Industries
Physician Billing rules
Review of Job Analysis and Job Description
 (WOM-2) one use per day
 (WOM-3) Daily additional review, up to 3.0 hrs per worker per day



EMPLOYER'S JOB DESCRIPTION

Job of Injury
 Permanent Modified Job
 Light duty/Transitional

Worker	Line District	Claim #	A328383
Company	St. Elsewhere Hospital	Job Title	Housekeeper, Modified Duty
Phone #	352-555-1289	FAX#	352-555-1299
Hours per day	Days per week		3
Employer Name (Please print)	Thomas Trauter	Title	Supervisor
Employer Signature			Date
			5/15/14

Essential Job Duties
 Dust, spray and wipe; straighten vacuum source; empty smaller trash cans; push light weight (80) vacuum on hard floors; suck small items in supply closet; use light dry mop (5000ft) on hard floors

Machinery, tools, equipment and personal protective equipment
 Dust cloth, 10 oz spray bottle, wet cloth, small trash cans, light weight vacuum, Swiffer-style dry mop.

Frequency Guidelines
 N: Never (not at all) S: Seldom (1-10% of the time)
 O: Occasional (11-33% of the time) F: Frequent (34%-66% of the time) C: Constant (67% to 100% of the time)

Physical Demands	Frequency	Description of Task (20+ descriptors)
Sitting	N	Breaks
Standing	F	While dusting and dry mopping
Walking	C	Walk on hard floors, carpeted floor continuously
Climbing Ladders/Stairs	S	May use elevator if needed
Twisting of the waist	O	May twist body while wiping
Bending/Stooping	O	No stooping
Squatting/Kneeling	N	
Crawling	N	
Reaching Out	C	Reach to dust, wipe, dry mop, vacuum R ARM ONLY
Working above shoulders	S	Dust high object R ARM ONLY
Handling/Carrying	C	Handling tools and small trash cans E ARM ONLY
Fine Finger Manipulation	O	Manipulate dry wipe, dusting cloths
Fast Controls/Driving	N	
Repetitive Motions	F	Repetitively reach out to fix cleaning tools
Talking/Hearing/Speaking	C	
Visual Tasks	N	
Lifting (10) lbs	S	Lift small trash cans to empty R ARM ONLY
Carrying (10) lbs	S	Trash can, light weight vacuum less than 10 feet R ARM ONLY
Pushing/Pulling (25) lbs	O	Push/Pull 80 vacuum on hard floor R ARM ONLY

Comments/Other (250 Characters) Primarily dust, wipe, vacuum and dry mop in offices and clinics. Can be done with no use of L&F arm.

FOR HEALTH PROVIDER'S USE ONLY

Provider Approval <input type="checkbox"/> Yes <input type="checkbox"/> No	Hours per day	Days per week	Effective date
If no, please provide objective medical documentation to support your decision.			
Provider Signature	Provider Name (Please print)	Date	

FD32-646-600 Employer's Job Description (4-2013)

Index: VDC

4. Example of Central Service job (foot injury)

Department of Labor and Industries
Physician Billing (only)
Review of Job Analysis and Job Description
10300/LAWS and JPD 001
102483-Each additional review up to five per worker per day



EMPLOYER'S JOB DESCRIPTION

Job at Injury
 Permanent Modified Job
 Light Duty/Transitional

Worker: Susan Kirtz	Claim #: Y7309157
Company: St. Elizabeths Hospital	Job Title: Product Scanner
Phone #: 332-332-1289 FAX#: 332-332-1295	Hours per day: 8 Days per week: 5
Employer Name (Please print): Louise Lane	Title: Supervisor
Employer Signature: _____	Date: 7/14/14

Essential Job Duties
Scan codes on product at inside (into central service). Open boxes, locate scan codes on product, scan, place product in the tub for other workers to place in temporary storage. Answer telephone. Greet occasional walk-in customer.

Machinery, tools, equipment and personal protective equipment
Scanner (various-weighted), box knife, telephone, message pad.

Frequency Guidelines
 N: Never (not at all) S: Seldom (1-10% of the time)
 O: Occasional (11-33% of the time) F: Frequent (34%+60% of the time) C: Constant (67%-100% of the time)

Physical Demands	Frequency	Description of Task (to characterize)
Sitting	C	Sit on stool or in office chair while scanning. Stand at will.
Standing	S	May choose to stand instead of sit.
Walking	S	Walk to location for scanning.
Climbing/Ladder/Stair	N	
Twisting at the waist	O	May reach down to reach to box of products on scanning deck.
Bending/Stooping	S	No stooping.
Squatting/Kneeling	S	
Crawling	N	
Reaching Out	C	Reach for product, reach while scanning.
Working above shoulders	S	
Handing/Twisting	C	Handing product to scan.
Foot/Finger Manipulation	F	Manipulate scanner and product.
Foot Control/Driving	N	
Repetitive Motion	F	Repetitively reach for product, repetitively trigger scanner.
Talking/Hearing/Speaking	C	
Vibratory Tasks	N	
Lifting (25 lbs)	O	May lift larger objects to be scanned, from cart back that 5 lbs.
Carrying () lbs	N	
Pushing/Pulling () lbs	N	

Comments/Other (250 Characters): Primarily used shipping box with cart, receive and scan products, then in cart for return to temporary storage. Sit on stool in office chair while scanning. Scanner gun is weight-restricted to avoid repetitive or sustained lifting.

FOR HEALTH PROVIDER'S USE ONLY

Provider Approval Yes No Hours per day _____ Days per week _____ Effective date _____

If so, please provide objective medical documentation to support your decision.

Provider Signature: _____ Provider Name (Please print): _____ Date: _____

(253-640-080) Employer's Job Description 10-0915 Index: VDC

5. *Tips about the Employer's Job Description form*

Some employers keep a list of potential light duty/modified tasks and look through those tasks to assemble the job description. The injured worker or other employees may be a good source of ideas as well. The effort you put into this form will save you time and money, so put forward your best ideas of what the worker can do for your company; you want productivity while keeping the worker safe within his or her work restrictions until released to full duty.

Employers can start by writing down the job tasks in the section labeled: *Essential Job Duties*. It is best to start with an action word, a verb like: scan or wipe or sort.

If the health care provider denies the job offer, they need to document objective ('measurable') reasons why the worker is unable to do what you have proposed.

When you fax the Employer's Job Description to the health care provider, you may want to include a face page telling the health care provider you will modify the job offer if the proposed tasks do not meet the restrictions. Do not hesitate to call the provider to clarify restrictions in order to write up a successful Job Description.

d. **JOB OFFER LETTER FOR ERTW**

1. Sample blank letter with guidance

While you have complete authorship for the job offer letter, all the essential information is in the enclosed sample letter. You may be able to conduct this transaction verbally, but the letter is oftentimes the best option. Complete the letter as soon as you have the signed job offer back from the health care provider.

SAMPLE JOB OFFER LETTER
(Complete Letterhead)

Date _____ Claim No. _____

Dear (Injured Employee Name):

I am pleased to offer you _____ temporary/transitional or _____ regular employment that will accommodate your current physical capacities. Your duties are described in the attached Job Analysis that has been approved by your doctor on _____.

Your work hours are _____ to _____ and you are scheduled to work _____ through _____, which is a _____ hour workweek. This position will pay _____ per _____. If this is less than 95% of your regular salary you may qualify for Loss of Earning Power benefits.

Your supervisor will be _____. He/she has been made aware of your current physical restrictions. The supervisor was also informed that your doctor has approved the job. Should you experience any difficulties in the performance of your duties, you are to report them to your supervisor immediately. It is our goal that all employees work in a safe and injury free environment.

I wish to welcome you back. Please report to your supervisor on _____ at _____ o'clock. Should you decide not to accept this offer of employment, please call me. If I do not hear from you and you do not report for work as scheduled, I will have to assume that you have decided not to accept this job offer. According to industrial insurance regulations your time loss benefits may be affected if you do not accept this job offer.

If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Name _____

Title: Claims Manager
Vocational Counselor
Physician

Attachments: Job analysis approved by attending physician

P252-033-000 L&I sample job offer form 4-02

2. Sample nursing ERTW job offer

St. Elsewhere

Date: January 13, 2014

Claim# A1526240

Dear John,

I am pleased to offer you temporary employment that will accommodate your current physical capacities. Your duties are described in the attached Job Description that was approved by your health care provider on January 13, 2014.

Your work hours are 8 am to 2 pm and you are scheduled to work Monday through Friday, a 30 hour work week. Your work will pay your usual hourly pay. If this is less than 95% of your regular pay, you may qualify for Loss of Earning Power benefit.

Your supervisor is Florence Knight. She is aware of your current restrictions and she knows that the health care provider has approved the attached job offer. If you have any difficulties with your job tasks, you are to report them to your supervisor immediately. We want you to be safe and heal up quickly.

We expect you to report to your supervisor at **8:00 am on January 15** on the third floor, room 3110. I spoke with you today, 1/13/14 and you told me you would be happy to accept the offered temporary job. If you decide not to accept this job offer, please call me. If I do not hear from you and you do not show up for work, I will understand you have decided not to accept this job offer. According to industrial insurance regulations, if you decide not to report for work your time loss benefits may be affected.

Please call me with any questions.

Gail Knight, RN

(509) 555-1212

Hand delivered to worker on 1/13/14

cc: Physician, claims manager

Attachment: approved job offer

3. Sample housekeeping ERTW offer

St. Elsewhere

Date: May 15, 2014

Claim# AJ28391

Dear Janet,

I am pleased to offer you temporary employment that will accommodate your current physical capacities. Your duties are described in the attached Job Offer that was approved by your health care provider on May 15, 2014.

Your work hours are 7 am to 3:30 pm with a 30 minute lunch, and you are scheduled to work Monday through Friday, a 40 hour work week. Your work will pay your usual hourly pay.

Your supervisor is Thomas Trainer. He is aware of your current restrictions and he knows that the health care provider has approved the attached job description. If you have any difficulties with your job tasks, you are to report them to your supervisor immediately. We want you to be safe and heal up quickly.

We expect you to report to your supervisor at **7:00 am on May 16, 2014** on the first floor, room 1108. I met with you on 5/15/14 and you told me you would accept the offered temporary job. If you decide not to accept this job offer, please call me. If I do not hear from you and you do not show up for work, I will understand you have decided not to accept this job offer. According to industrial insurance regulations, if you decide not to report for work your time loss benefits may be affected.

Please call me with any questions.

Gail Knight, RN

(509) 555-1212

Hand delivered to worker on 5/15/14

cc: Physician, claims manager

Attachment: approved job offer

4. Sample Central Service ERTW offer

St. Elsewhere

Date: July 15, 2014

Claim# Y7309157

Dear Susan Kiew,

I am pleased to offer you temporary employment that will accommodate your current physical capacities. Your duties are described in the attached Job Offer that was approved by your health care provider on 7/14/14.

Your work hours are your usual hours from 3 pm to 12:00 am (midnight). You are scheduled to work Monday through Friday, a 40 hour work week. Your work will pay your usual hourly pay.

Your supervisor is Louise Lane. She is aware of your current restrictions and she knows that the health care provider has approved the attached job offer. If you have any difficulties with your job tasks, you are to report them to your supervisor immediately. We want you to be safe and heal up quickly.

We expect you to report to your supervisor at **3:00 pm on July 16, 2014** on the third floor, room 3110. I spoke with you today, 7/15/14 and you told me you would be happy to accept the offered temporary job. If you decide not to accept this job offer, please call me. If I do not hear from you and you do not show up for work, I will understand you have decided not to accept this job offer. According to industrial insurance regulations, if you decide not to report for work your time loss benefits may be affected.

Please call me with any questions.

Gail Knight, RN
(509) 555-1212

Hand delivered to worker on 7/15/14

cc: Physician, claims manager

Attachment: approved job offer

5. *Tips on writing the ERTW offer letter*

The first three days off after injury are taken from the injured worker's sick leave or paid leave. The claim does not start paying time loss until the fourth day. To keep workers' compensation insurance costs as low as possible, strive to get the worker back to work in ERTW within those first three days.

It is important that the ERTW job offer letter provides clear and concise expectations about the injured workers' return to work. Fax the job offer letter that you gave the injured worker to the claims manager at **(360) 902-6100**.

If the worker fails to appear for work, be sure to tell the claims manager.

The Employer's Job Description that the health care provider approved is the only work the injured worker may do. The employee must stay within the written medical restrictions. If the worker feels he or she is not able to do that level of work, the worker must return to the health care provider to discuss the problem.

EMPLOYER'S GUIDE TO ERTW REIMBURSEMENT THROUGH THE STAY AT WORK PROGRAM

Labor and Industries will pay half the base salary of an injured worker who is permitted to return to work while recovering from their injury. Of course there are a few requirements for this to happen.

a. Reimbursement Allocation

An eligible employer will get reimbursed 50% of the worker's base salary for up to 66 days or \$10,000. Plus you may be reimbursed for training and tools the worker needs to do the modified job.

b. Reimbursement Procedure

- (1) Develop a modified job within the injured worker's restrictions
- (2) Fill out the Employer's Job Description form
(see examples earlier in the ToolBox)
- (3) Offer the job to the injured worker and the worker accepts
- (4) Provide time sheets and payroll records.
- (5) Fax the following to L&I: **(360-902-6100)**
 - a. Activity Prescription Form APF (see examples earlier in the ToolBox)
 - b. Job Description for the light duty job/modified duty, signed by the health care provider (see examples earlier in the ToolBox)
 - c. Payroll record and daily timesheets.

c. How to File a Wage Reimbursement Claim with Labor and Industries?

Fax the APF, the health care provider-signed Job Description Offer, the payroll record and the daily timesheets to **(360) 902 6100**. Copies of everything you need to submit are available at: <http://www.lni.wa.gov/Main/StayAtWork/>

1. Blank copy of the Stay At Work (SAW) Reimbursement request form. Available at:

<http://www.lni.wa.gov/FormPub/Detail.asp?DocID=2515>

Department of Labor and Industries
Insurance Services Commission
PO Box 44281
Olympia WA 98504-4281



Stay at Work Wage

Reimbursement Application for Employers

Apply immediately for expenses incurred between:

Employer:
Business Name: _____
LAI Account #: _____

Injured Worker:
Name: _____
LAI Claim #: _____

Mail Reimbursement to:
Mailing Address Line #1: _____
Mailing Address Line #2: _____
City: _____ State: _____ Zip Code: _____

Job Description Before Injury:
Example: Warehouse Worker - Pallet Jacking

Light-duty or Transitional Job Description:
Example: Inventory Control Clerk

Apply here for reimbursement of 85% of base wages you paid for up to 60 days or \$13,683 (whichever comes first).

Notes: Don't include tips, commissions, bonuses, board, housing, fuel, health care benefits, etc. (See page 2 for more on base wages.)

I pay my worker a fixed salary. Yes No I keep track of the number of hours worked. Yes No

Notes:
Gather worker's pay records including daily timesheets showing hours worked each day. These records will help you complete this section. You'll also need to send copies of the records with this form. (See page 2)

Time period of light-duty or transitional work: _____
Start: _____ End: _____
Intermittent (swing or graveyard shift) Yes No

Base wage for light-duty or transitional work - rate: \$ _____ per _____
(Use same # of hrs for all base wages.)

Total # of days requested (employee actually worked light duty) _____

Total base wage paid this period for light-duty or transitional work: \$ _____

85% amount you're requesting: \$ _____

Notes:

- When you enter base wages:
 - Include only hours and wages paid for work performed.
 - Don't include holiday pay, vacation pay, sick leave, or similar payments or benefits.

	Date	# Hrs	Total Daily Wage	Date	# Hrs	Total Daily Wage	Date	# Hrs	Total Daily Wage

Notes: Enter dates, # of hours, and total daily wage paid for each day's work. Example: 8 hrs x \$11/hr = \$88.00 total daily wage. Don't apply for the date of injury as it is not reimbursable. You must apply within one year of the date the work was performed.

Sign below to confirm the information on this form is true and accurate. Important: Attach required documents listed on page 2.

Signature: _____ Printed Name and Title: _____
Date (mm/dd/yyyy): _____ Phone # in Case We Need to Contact You: _____

FAX to: 360-902-6100 (Or mail to address above.)
Questions? 1-888-426-3482, toll-free, or 360-902-4417

Index: **STAY**

FD-902 (08) Saw & Work Reimbursement Application for Employers (01/2013)

2. SAW Wage Reimbursement Form example for nurse John Sampler:

Department of Labor and Industries
 Insurance Services Administration
 PO Box 14201
 Olympia, WA 98504-4201



Stay at Work Wage
 Reimbursement Application for **Employers**
Apply separately for expense reimbursement.

Employer:

Business Name: St. Elizabeth Hospital
 L&I Account #: 880792

Injured Worker:

Name: John Sampler
 L&I Claim #: A150040

Mail Reimbursement to:

Mailing Address Line #1: 11204 E. Whitlock Rd
 Mailing Address Line #2:
 City: Colville State: WA Zip Code: 99001

Job Description Before Injury:

Example: Warehouse Worker - Produce packing
 Registered Nurse - rehabilitation unit

Light-duty or Transitional Job Description:

Example: Inventory Control Clerk
 Unit manager assistant - rehabilitation unit

Apply here for reimbursement of 50% of base wages you paid for up to 66 days or \$15,000 (whichever comes first).
 Hints: Don't include tips, commissions, bonuses, board, housing, fuel, health care benefits, etc. (See page 2 for more on base wages.)

I pay my worker a fixed salary. Yes No **I keep track of the number of hours worked:** Yes No

Hints: Gather worker's pay records including daily timesheets showing hours worked each day. These records will help you complete this section. You'll also need to send copies of the records with this form. (See page 2)

Time period of light-duty or transitional work: 01/15/15 to 01/28/15
 Worked evening or graveyard shift? Yes No
 Base wage for light-duty or transitional work - rate: \$ 20.00 per hr
 Total # of days reported (employee actually worked light duty): 12
 Total base wage paid this period for light-duty or transitional work: \$ 240.00
 50% amount you're requesting: \$ 120.00

Hints: When you enter base wages:
 • Include only hours and wages paid for work performed.
 • Don't include holiday pay, vacation pay, sick leave, or similar payments or benefits.

Date	# Hrs	Total Daily Wage	Date	# Hrs	Total Daily Wage	Date	# Hrs	Total Daily Wage
1/15/15	8	160.00						
1/16/15	8	160.00						
1/17/15	8	160.00						
1/20/15	8	160.00						
1/21/15	8	160.00						
1/22/15	8	160.00						
1/23/15	8	160.00						
1/26/15	8	160.00						
1/27/15	8	160.00						
1/28/15	8	160.00						

Hints: Enter dates, # of hours, and total daily wage paid for each day's work. Example: 8 hrs x \$16/hr = \$128 total daily wage. Don't apply for the date of injury as it is not reimbursable. You must apply within one year of the date the work was performed.

Sign below to confirm the information on this form is true and accurate. Important: Attach required documents listed on page 2.

Signature	Printed Name and Title
Date (mm/dd/yyyy) 02/17/15	Please Fill Out, We Need to Contact You 206-528-1218

FAX to: 360-962-6100 (Or mail to address above)
 Questions? 1-866-406-2482, toll-free or 360-902-4411

Index: STAY

3. *Sample FAX cover page for a Stay At Work Wage Reimbursement Packet:*

FAX

TO: Labor & Industries Fax #: (360) 902-6100
FROM: Gail Knight, St. Elsewhere Hospital
Phone: (509) 555-1212 Fax #: (555) 555-1299
DATE: 2/17/2015

STAY AT WORK WAGE REIMBURSEMENT SUBMISSION

INJURED WORKER: John Sampler

Claim #: **A1526240** Date of Injury: 1/13/15

We are applying for the SAW Wage Reimbursement for this injured worker. Attached are (1) Activity Prescription Form (2) Signed Job Description for modified duty job (3) Payroll record and (4) Daily time sheet.

The amount of reimbursement is \$900.00.

Please contact me with any questions. Please forward the reimbursement to the address listed on our L&I account.

RESOURCES

Telephone

Claims Manager: 1-800-LISTENS

Your Local L&I Office ERTW Contacts:

Region 1

Northwest Washington

Bellingham 360-647-7300

Everett 425-290-1300

Mount Vernon 360-416-3000

Region 2

King County

Bellevue 425-990-1400

Seattle 206-515-2800

Tukwila 206-835-1000

Region 3

Pierce County/Peninsula

Bremerton 360-415-4000

Port Angeles 360-417-2700

Tacoma 253-596-3800

Region 4

Southwest Washington

Aberdeen 360-533-8200

Kelso 360-575-6900

Tumwater 360-902-5799

Vancouver 360-896-2300

Region 5

Central Washington

East Wenatchee 509-886-6500

Kennewick 509-735-0100

Moses Lake 509-764-6900

Yakima 509-454-3700

Region 6

Eastern Washington

Pullman 509-334-5296

Spokane 509-324-2600

Websites

Insurance for business: the section of L&I's website specifically for employers. <http://www.Lni.wa.gov/ClaimsIns/Insurance>

Washington Stay at Work: the section of L&I's website with information about financial incentives to assist employers in bringing back workers to light-duty or transitional work. <http://www.Lni.wa.gov/Main/StayAtWork/>

Employers can access a workplace injury claim or their industrial insurance account through the Claim & Account Center at <http://www.ClaimInfo.Lni.wa.gov>. The site is generally available weekdays 6 a.m.–11:30 p.m. and on weekend days.

READING AND WORKBOOKS

*If the document fails to load from the links below, copy and past the link into your browser.

The Employer's Return-to-Work Guide is at <http://www.lni.wa.gov/IPUB/200-003-000.pdf>. This guide will explain how to get your workers back to work quickly after an injury.

Getting Back to Work: It's Your Job and Your Future is at <http://www.lni.wa.gov/IPUB/200-001-000.pdf>. Explain to your workers their responsibilities toward getting back to work following an injury. Makes a good handout during ERTW training.

The Complete Stay at Work Guide for Employers is at <http://www.lni.wa.gov/IPUB/243-005-000.pdf>. It will explain the Wage Reimbursement process to help keep employees on the job while they heal up.

Employers' Guide to Industrial Insurance is at <http://www.lni.wa.gov/IPUB/101-002-000.pdf>. This guide explains your responsibilities as an employer regarding industrial insurance.

State Fund Return to Work: Developing and Maintaining a Successful Return to Work Program. <http://www.statefundca.com/pdf/e13490.pdf>. Pages 5-7 through 5-18 offer a generic list for potential temporary transitional jobs for all industries.

Funding and support for this project has been provided by the State of Washington, Department of Labor & Industries, Safety & Health Investment Projects (SHIP).

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Special thanks to the following businesses:

Deaconess Hospital, Spokane, WA
Georgia Pacific, Camas, WA
Keller Williams Realty, Spokane, WA
Peace Health, Vancouver, WA
Rockwood Clinics, Spokane, WA
Valley Hospital, Spokane Valley, WA
Wafer Tech, Camas, WA