The Town of Fort Frances	**SECTION** HEALTH AND SAFETY
MODIFIED WORK PROGRAM **POLICY**	**NEW:** May 2004 **REVISED:** November 2007
Resolution No. **406 (consent) 11/07**	Supercedes Resolution No.
Policy Number 5.23	**PAGE 1 of 5**

PURPOSE

The Town of Fort Frances will make every reasonable effort to provide temporary modified or suitable alternative duties to a worker who is disabled because of an occupational injury or illness. Our goal is to provide injured workers with the opportunity to return to work within their level of ability as soon as possible following the injury/illness.

The Town of Fort Frances will comply with all legislative requirements including those of the Workplace Safety and Insurance Act (WSIA), the Ontario Human Rights Code and the Employment Standards Act.

The goal of the Early and Safe Return to Work Program is to return workers to their pre-injury / illness position in a timely manner. This may be accomplished through temporary modification to the tasks, work environment or working hours (for up to twelve (12) weeks, at the end of which there will be a review and an extension if necessary). Where modifications to the pre-injury / illness position are not possible or appropriate, alternate duties may be sought and used to facilitate the worker's early and safe return to work

Where a permanent impairment prevents the worker from returning to their pre-injury / illness position, the Town of Fort Frances will work with WSIB to explore alternatives in accordance with all legislative requirements.

DEFINITIONS

Temporary modified work is where the worker's regular job is modified for a designated time period to assist in rehabilitation following an injury or illness. The worker is able to perform the essential duties of the job, but some of the other duties are modified to suit the worker's limitations / capabilities.

Temporary alternative work is other suitable work that is provided to a worker for a designated time period to assist in rehabilitation following an injury or illness.

Permanent impairment is a disability that a health care practitioner advises is not likely to improve significantly over time.

Suitable alternative work is work that the worker can do which is consistent with his/her limitations and capabilities and which can be performed without aggravating the injury/illness.

Functional Abilities Form for Early Return to Work is a form that the health care practitioner completes stating the worker's current limitations and capabilities**.**

Health Care Practitioner includes a medical doctor, chiropractor, physiotherapist, dentist.

RESPONSIBILITY

Division Managers shall:

- Develop knowledge and understanding of the program and disability management.
- Ensure that all workers understand the early intervention and modified work program with the expectation that the WORKER participating in the program will fully participate and cooperate with the objective to return to regular duties.
- Participate in the promotion and provision of modified work, provide continued support and encouragement to workers participating in the program.
- Participate in program meetings as required.

Supervisor shall:

- Remain in regular contact with the injured / ill worker during the period of absence from work.
- Provide the injured / ill worker with appropriate forms (WSIB Functional Abilities Form) to take to the health care practitioner at the first opportunity, preferably at initial treatment.
- Try to identify temporary modified or alternative duties where required in accordance with the terms of the Collective Agreement when forms have been received outlining the worker's fitness for work.
- Meet with the worker and other parties where possible, to discuss the terms of the return to work.
- Notify appropriate parties of the worker's return to work (either modified, alternative or full duties) so that the WSIB can be advised.

Worker shall:

- Obtain medical approval from a health care practitioner for a modified work program using the WSIB Functional Abilities form and return same to supervisor as soon as possible.
- Participate and cooperate in the program by maintaining regular personal contact with the supervisor regarding the ability to work, physical capabilities and treatment plans.
- Follow the treatment plan outlined by the health care practitioner.
- Communicate any concerns to the supervisor so that potential problems or concerns are openly addressed in a timely manner.

Return To Work Process

The worker shall report the injury/illness to their immediate supervisor and provide appropriate health care practitioner's certificate for time off or return to modified work.

When the worker is able to return to modified duties, he/she will provide documentation from the health care practitioner outlining his/her current physical capabilities and the expected date of recovery or return to regular duties.

A Return to Work meeting will take place to determine what work might be available to suit the worker's capabilities and limitation. The meeting should include the injured worker, the supervisor and any other appropriate parties. Modified duties should be offered within the worker's department.

The **MODIFIED WORK PROGRAM & EARLY RETURN TO WORK PLAN** Form will be completed outlining the goals and details of the worker's return to work. The final goal is to return to regular duties, with short-term goals of modified work, modified hours or other suitable and available duties as required. The details of the plan include a start and end date, physical restrictions, hours of work, and scheduled review dates of the plan (at least every 4 weeks). A copy shall be provided to each of the parties including the WSIB. Where possible the health care practitioner should be provided with a description of the worker's regular duties (job description) and the modified duties being offered.

Temporary modified/alternate work will be offered for a limited period of time as outlined in the modified work plan. In the case where return to regular duties does not occur as expected, the workplace parties will meet to revise and reassess the continuing need for and availability of modified duties.

If medical documentation is received indicating that the injury/illness is likely to be permanent and the worker is not ever expected to recover sufficiently to perform the essential duties of their regular work, appropriate parties will be notified and will work with WSIB to explore alternatives in accordance with all legislative requirements.

TOWN OF FORT FRANCES

MODIFIED WORK PROGRAM & EARLY RETURN TO WORK PLAN

Employee's Name:	**Date of Injury/Illness:**
Department:	**Nature of Injury/Illness:**
Position:	**Last Day Worked:**
Supervisor:	**WSIB Claim # (if applicable):**

MODIFIED JOB DESCRIPTION (Include any and all restrictions as described by a health care practitioner):

Days/Hours: S.....M.....T.....W.....T.....F.....S.....

Site Assigned to:

Duties:

Date to Commence Accommodated Work Plan:

Anticipated Date to Complete Accommodated Work Plan:

I, _____ agree to participate in this Accommodated Work Plan
(name of employee)

Signature of Employee:_____ **Date:** _____

Signature of Human Resources Manager: _____

Date:

Signature of Supervisor:	**Date:**
Claims Adjudicator (if applicable) Notified By:	**Date:**

Please return completed form to the Human Resources Manager for signing. Copies will then be distributed to the Supervisor as well as to the employee

MODIFIED WORK PROGRESS REPORT

In an effort to ensure the success of the Modified Work Program the following form has been designed to ensure that regular, meaningful follow-up is provided to all employees engaged in the Program.

Employee's Name:	**Employee's Position:**
Week #:	**Rate of Pay:**

List the duties assigned to the employee during the preceding week:

List any observations that you have made of the employee's progress:

At your follow-up sessions, what was reported by the employee:

List the duties assigned for the upcoming week, highlighting any variances from the plan set at the outset of the program:

Supervisor / Manager or Designate - Recommendations/Comments:

Supervisor's Signature: _____ Date: _____