Sample Cover Letter/instructions for Injured Worker

Company name & address

Contact name & number

Dear Employee,

We are sorry to learn of your injury and your recovery is important to us. (Company Name) is committed to ensuring the safety and health of our employees, and it is important to learn how your injury occurred so preventative measures can be taken in the future.

(Company Name) has a Temporary Transitional duty program to aid in the recovery process following an on-the-job injury. Should your injury require that you work a transitional **temporary** job during recovery please help us by clearly communicating any injury-related problems you have performing your assigned duties.

Below is a list of what needs to be done immediately following **every** workplace injury.

Injuries not requiring immediate medical care:

The injured employee and supervisor must complete the company's Accident Report regardless of whether medical care is needed at the time. The reasons for completing the required paperwork are

- By reporting injuries (Company Name) can correct unsafe conditions or actions
- The injury may require medical care at a later date
- Should the injury require medical care at a later date (Company Name) will have the required information necessary for processing an L&I claim and completing our OSHA log.

Injuries requiring medical care:

- The Accident Report must be completed.
- If medical care is needed the employee must take the Injured Worker Packet to the doctor's office and inform the doctor that (Company Name) has a return to work program and may provide temporary transitional work during recovery.
- The employee must return the *Transitional Duty Form* and the *Activity Prescription Form* the same or next day of their doctor's visit to their supervisor.

If released to modified duty:

- The Claims Coordinator will provide you with a *Job Offer Letter* prior to starting the next shift.
- The supervisor must not assign work that exceeds restrictions, and you must work within your limitation as outlined by the attending physician.
- At each follow-up appointment you will provide the doctor or other medical practitioner with a new *Transitional Duty Form* and *Activity Prescription Form* for updating. The updated forms must be provided to your supervisor upon returning to work.
- All modified duty jobs are **temporary** in nature and (Company Name) anticipates you will be able to return to the job-of-injury.

Return-to-Work Authorization

(Required to be approved by Doctor)

Company name & address
Contact name & number

Employee:
Job Title:
Date of Injury:

Dear Attending Physician:

We are a proactive company and care about our workers. We recognize early Return-To-Work as being important to the workers' psychological, financial, and physical wellbeing.

Your assistance is appreciated!

We have also included the job of injury, and a job description for a ***modified / light duty / transitional*** position we have available if our employee is not released to their job of injury. Further adjustment to these positions may be possible if needed.

Please complete the Activity Prescription Form and include any comments on our employee's ability to work. Please give a copy of the completed form to our employee or fax to (Add Number).

Please call if you have any questions.

Sincerely,

_____ _____
Attending Physician Date

Department of Labor and Industries

Physician Billing codes
Review of Job Analysis and Job Description
1038M-Limit one per day
1028M-Each additional review, up to five per worker per day

EMPLOYER'S JOB DESCRIPTION

☐ Job of Injury
☐ Permanent Modified Job
☐ Light duty/Transitional

Worker	*****	Claim #	*****
Company	*****	Job Title	*****
Phone #	*****	FAX# *****	Hours per day *****
Days per week *****			
Employer Name (Please print)	*****	Title *****	
Employer Signature		Date *****	

Essential Job Duties
*****

Machinery, tools, equipment and personal protective equipment
*****

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%-100% of the time)

Physical Demands	**Frequency**	**Description of Task** *(80 characters)*
Sitting		*****
Standing		*****
Walking		*****
Climbing Ladders/Stairs		*****
Twisting at the waist		*****
Bending/Stooping		*****
Squatting/Kneeling		*****
Crawling		*****
Reaching Out		*****
Working above shoulders		*****
Handling/Grasping		*****
Fine Finger Manipulation		*****
Foot Controls/Driving		*****
Repetitive Motion		*****
Talking/Hearing/Seeing		*****
Vibratory Tasks		*****
Lifting (*****) lbs		*****
Carrying (*****) lbs		*****
Pushing/Pulling (*****) lbs		*****

Comments/Other: *(270 Characters)* *****

FOR HEALTH PROVIDER'S USE ONLY

Provider Approval ☐ Yes ☐ 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 *****

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

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):
_____/_____/_____ to _____/_____/_____

☐ 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 24/7, please estimate capacities below and provide key objective findings at right.

Required: Key Objective Finding(s)

Required: Estimate what the worker can do *Unless released to JO!*

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

Worker can: (Related to work injury.) Blank space = Not restricted	Never	Seldom 1-10% 0-1 hour	Occasional 11-33% 1-3 hours	Frequent 34-66% 3-6 hours	Constant 67-100% Not restricted
Sit	☐	☐	☐	☐	☐
Stand / Walk	☐	☐	☐	☐	☐
Climb (ladder / stairs)	☐	☐	☐	☐	☐
Twist	☐	☐	☐	☐	☐
Bend / Stoop	☐	☐	☐	☐	☐
Squat / Kneel	☐	☐	☐	☐	☐
Crawl	☐	☐	☐	☐	☐
Reach Left, Right, Both	☐	☐	☐	☐	☐
Work above shoulders L, R, B	☐	☐	☐	☐	☐
Keyboard L, R, B	☐	☐	☐	☐	☐
Wrist (flexion/extension) L, R, B	☐	☐	☐	☐	☐
Grasp (forceful) L, R, B	☐	☐	☐	☐	☐
Fine manipulation L, R, B	☐	☐	☐	☐	☐
Operate foot controls L, R, B	☐	☐	☐	☐	☐
Vibratory tasks; high impact	☐	☐	☐	☐	☐
Vibratory tasks; low impact	☐	☐	☐	☐	☐

Lifting / Pushing	Never	Seldom	Occas.	Frequent	Constant
Example	*50 lbs*	*20 lbs*	*10 lbs*	*0 lbs*	*0 lbs*
Lift L, R, B	____lbs	____lbs	____lbs	____lbs	____lbs
Carry L, R, B	____lbs	____lbs	____lbs	____lbs	____lbs
Push / Pull L, R, B	____lbs	____lbs	____lbs	____lbs	____lbs

Other Restrictions / Instructions:

Employer Notified of Capacities? ☐Yes ☐No
Modified duty available? ☐Yes ☐No
Date of contact: _____/_____/_____
Name of contact:_____
Notes:

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: _____ 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**): _____ ☐ Doctor ☐ ARNP ☐ PA-C ( )____-_____ Phone number Date: ____/____/____

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

State Fund Claims: Fax to claim file. *Choose any number:* 360-902-4292 360-902-4565 360-902-4566 360-902-4567 360-902-5230 360-902-6100 360-902-6252 360-902-6460

*Self-Insured Claims: For a list of SIE/TPAs, go to: www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp

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

Physician's Signature:_____ Date: _____

Sample Formal Job Offer to injured worker

Date:

Employee's Name
Address
City, State, Zip Code

Re: ***Claim #_____***

Dear _____:

Your doctor has released you for modified duty work, which ***he/she*** feels you are able to do until you can return to your regular job. Therefore, we would like to offer you the temporary, modified duty job of **_____.** Attached is a copy of the job description approved by your attending doctor.

Please report to your immediate supervisor for your modified duty job on ***(insert date)*** at ***(insert time AM/PM)***. Your pay will be ***$_____ per _____(hour/month)***. Loss of Earning Power (LEP) benefits may apply if your restricted duty wage is less than your regular wage.

As you improve, the physical demands of the job may change, as approved by your doctor. Usually, a modified duty assignment lasts anywhere from a few days to several weeks, depending on your medical condition.

Your signature below indicates that you have reviewed this offer. Please return this signed job offer agreement to me by ***(insert date—10 to 14 days from date of letter)***. A self-addressed, stamped envelope is enclosed for your convenience.

Should you have any questions about this job offer, please contact me at **Your Phone#**.

Sincerely,

CHECK ONE:

I accept this job offer: _____ I do not accept this job offer: _____

_____ _____
Employee Signature Date

Enclosures: Approved Job Description
Extra Copy of this letter for employee's records

CC: Claims Manage