Print Forms and Instructions

OCCUPATIONAL HEALTH ASSESSMENT FORM

A To be completed by employee

This form must be returned to your supervisor/principal within 24 hours of being away from work due to an injury or illness. Direct contact with your supervisor/principal must be maintained to facilitate participation in alternate or modified work.

First name: _____ Last name: _____

Employee phone number: _____ Department/School: _____

Date of injury: _____

Authorization to release information

I understand that alternate/modified duties are available in my workplace, and authorize my health-care provider _____ to release my functional (work) abilities to the division.
(print name and qualifications)

Employee signature: _____ Date: _____

B To be completed by health-care provider

On the basis of my examination, this employee:

1 Is able to return to regular duties: ❑ yes ❑ no

2 Is able to return to duties, provided they *do not* perform the following activities:

❑ lift 0-10 lbs	❑ push and pull	❑ squat	❑ stand	❑ twist
❑ lift 11-25 lbs	❑ work with hands	❑ climb	❑ sit	❑ drive
❑ lift 25+ lbs	❑ bend	❑ reach	❑ work above the shoulders	

Comments:

_____

_____

_____

Date: _____

Signature of health-care provider: _____

Health-care provider's phone number: _____

Date of next appointment: _____

River East Transcona
SCHOOL DIVISION

RETSD DISABILITY MANAGEMENT PROGRAM

Reporting and Managing a Work-related Injury • Non-teaching Employees

Responsibilities and Processes for Supervisors/Principals

1. Assist with appropriate first aid and/or arrange for transportation of the injured employee by ambulance or taxi to a medical facility if required. Transportation type depends on the nature and severity of the injury.

2. Give the employee a ***Reporting a Work-related Injury*** package for non-teaching employees. It includes a brochure outlining the RETSD Disability Management Program, Employee Statement of Injury form and an Occupational Health Assessment (OHAF)/Return to Work Plan (RTWP) form.

3. If possible, have the employee complete the Employee Statement of Injury form. This form, as well as others, can also be found on the RETSD website by following the links: www.retsd.mb.ca>Human Resources>Workplace Safety and Health>Forms (pull down menu).

4. Ensure the employee knows that a health-care provider must complete an OHAF if medical attention is sought. It is the employee's responsibility to discuss the Disability Management Program with the health-care provider.

5. Obtain the Employee Statement of Injury form from the employee. Complete an Accident Investigation Report, WCB report and send all three to Human Resources. Forms can be found on the RETSD website.

6. Upon return from the medical practitioner/hospital/clinic, obtain the OHAF from the employee and review the documented capabilities or restrictions/limitations for accommodation in modified or alternate work.

7. If the employee does not return to work immediately, the employee has the primary responsibility to maintain weekly phone contact with you regarding his/her progress. Ensure you have the employee's current phone number. Document all phone calls and communication.

8. When the employee returns to work, consult with him/her regarding the OHAF and his/her capabilities and limitations, and then work together to develop the RTWP.

9. Send a copy of the completed OHAF/RTWP to Human Resources.

10. In consultation with Human Resources, monitor progress and report any obstacles or non-compliance with the RTWP.

11. Request updated OHAFs from the employee as necessary. Consult the employee and modify duties outlined in the RTWP as required. Review updated OHAF/RTWP with Human Resources.

12. Keep Human Resources informed of the employee's progress.

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EMPLOYEE STATEMENT OF INJURY

1 Employee information (please print)

First name: _____ Last name: _____

Department/School: _____

Date of injury: _____ Time of injury: _____

2 The following is a notice of an injury that has taken place.

❑ A health-care provider *will be* or *has been seen*. ❑ A health-care provider *will not* or *has not been seen*.

3 Describe your injury. Please be specific.

_____

_____

_____

4 Describe how the injury happened. Please be specific.

_____

_____

_____

_____

5 Employee signature

I understand my responsibilities to:

a. Complete and return this form to my supervisor/principal on the date of the injury or as soon as possible
b. Tell my health-care provider that the division offers modified work options to assist in my return to work
c. Report back to my supervisor/principal after receiving medical attention and to submit the Occupational Health Assessment Form completed by my health-care provider.

Employee signature: _____ Date: _____

Supervisor/principal signature: _____

Form completed by (if completed by someone other than employee):

Print name: _____

Signature: _____ Date: _____

River East Transcona
SCHOOL DIVISION

RETURN TO WORK PLAN

This return to work plan has been developed by the employee, and the supervisor/principal at River East Transcona School Division exclusively for _____ (print employee name), and takes into account the capabilities and restrictions identified by the employee's health-care provider on the Occupational Health Assessment Form.

Start date: _____ Follow-up/end date: _____

Department/School: _____

Number of work days: _____ Number of hours per day: _____

Modified job options:

1. _____
2. _____
3. _____

We agree to abide by this plan in an effort to succeed with a safe and fair return to work. Each party has an obligation to advise the others of any circumstances that might affect the plan. Changes to this agreement must meet the approval of all original parties.

Employee (print name): _____ Date: _____

Signature: _____

Supervisor/principal (print name): _____ Date: _____

Signature: _____

I have discussed the above plan with my supervisor/principal and I am refusing to participate. I understand that my refusal to participate will be reviewed by my employer and may result in the loss of benefits.

Employee (print name): _____ Date: _____

Signature: _____

Supervisor/principal (print name): _____ Date: _____

Signature: _____

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