This sample policy/procedure must be customized to fit the needs of your company. It must be integrated into other policies/procedures and processes as required. This is not meant to be used "as-is", but must be adapted to reflect your company needs and processes.

[insert company info here]

RETURN TO WORK REQUIREMENTS, FORMS & TOOLS

Date of Issue:	
Written by:	**Date:**
Reviewed by:	**Date:**
Approved by:	**Date:**

PURPOSE

A return-to-work (RTW) plan is a written document developed collaboratively by the injured or ill worker, the worker's supervisor or manager, the treating health professional (through the provision of functional abilities information) and, where appropriate, the RTW Co-ordinator and/or Union Representative. The Return-to-Work (RTW) Plan is developed with a focus on creating a return to work plan, promote consistent administration, helps prevent future injury and promote recovery of the injured/ill person.

SCOPE

This standard applies to all employees, supervisor and owner.

RELATED DOCUMENTATION

Internal

- Document 1: Functional Abilities Form
- Document 2: Return-to Work-Plan
- Document 3: Contact Log
- Document 4: Return to Work Progress Report
- Document 5: Physical and Cognitive Demands Analysis (regular and transitional assignments)
- Document 6: Letter to Health Care Practitioner
- Document 7: Modified work offer letter to injured/ill person
- Document 8: Medical Consent for release of information
- Document 9: Return-to-work plan closure and evaluation feedback forms

External

- Workplace Safety and Insurance Board
- WSIB Workwell Evaluation Templates

DEFINITIONS	
Functional Abilities Form	The purpose is to keep track if contact with the workers as well as treating health care professionals and case managers. Your company will decide on the frequency of contact and the method of contact such as telephone follow-up with the worker, one -on-one meetings, emails or letters.
Return to Work Plan	
Contract Log	The purpose is to keep track if contact with the workers as well as treating health care professionals and case managers. Your company will decide on the frequency of contact and the method of contact such as telephone follow-up with the worker, one -on-one meetings, emails or letters.
Return to Work Progress Report	The purpose is to monitor and record the worker's progress while they are accommodated on modified duties. Regular meetings and communication provide both parties with an opportunity to discuss any concerns the worker may be experiencing
Physical and Cognitive Demands Analysis	A Physical Demands Analysis is a systematic procedure to quantify and evaluate all the physical and environmental demand components of all essential and non-essential tasks of a job. A cognitive demand analysis (CDA) is designed to provide an assessment of a workplace and identify the essential job duties and cognitive demands of a job.
Letter to Health Care Practitioner	The purpose of the letter is to inform the treating health care practitioner of the company's RTW program and its willingness to work together with them and the worker as per the restrictions
Return to Work Closure/ Evaluation Report	The purpose is to evaluate the results by having both worker and the worker's supervisor or manage complete a Return to work Closure/Evaluate Report. The evaluation report provides employer with information on what worker and the opportunities for improvement
Regulated Health Care Professional	An external treatment provider who is regulated and licensed to practice health care in Ontario.
Medical File	Medical Documentation provided by the employee or the employee's attending healthcare provider to be kept in control by [Your Company] for the purposes of assessing a request for medical accommodation and/or absence from work, documents medical precaution, and/or return to work planning
Modified work	• **Work hardening** – increasing a worker's strength gradually by combining regular and modified job duties; • **Transitional/Modified work** – when an injured employee, while active in an ESRTW program, is temporarily performing activities other than their pre-injury activities during the recovery period of their work-related injury; • **Reduced hours** – reducing an employee's hours of work; • **Gradual increase in hours** – beginning with reduced hours and increasing the number of hours worked gradually;

	• **Work adjustment** – modify the employee's regular job to meet restrictions;

ROLES & RESPONSIBILITIES
Senior Management is responsible for: • Establish, monitor and support the progress of all employees participating in an RTW plan and maintain records of the employee's progress and up to date restrictions till the end of the plan • Allocate human and financial resources for the administration of the RTW Program • Provide training and education to all managers, supervisors and workers regarding the program • Provide a safe work environment **Manager/Supervisor is responsible for:** • Developing individual RTW written plan as per the restrictions with the injured employee • In collaboration with your worker and union representative (if applicable) identify and provide modified or alternative work consistent with worker's functional abilities restriction and address any concerns as they may arise • Regular follow-up and communication with the injured worker and to monitor and record worker's progress in the plan • Provide WSIB with a copy of RTW plan and supervise and maintain the plan **Employees are responsible for:** • Cooperate, follow-up and maintain regular communication during the RTW plan with the Manager/Supervisor and WSIB • Participate in prescribed treatment and rehabilitation programs • Assist employer to identify suitable and available work, consistent with functional abilities and where possible, restores pre-injury earnings • Cooperate, follow-up and maintain regular communication during the RTW plan with the Manager/Supervisor and WSIB • Comply with medical and rehabilitation treatment and arrange appointments during non-work hours wherever possible

- Maintain regular contact with the supervisor/RTWC during periods of absence and while participating in a RTW plan
- Attend all scheduled RTW meetings
- Contribute to the development of the RTW plan.
- Communicate any concerns to the supervisor/RTWC
- Immediately advise the supervisor /RTWC of changes in circumstances

Health and Safety Coordinator is responsible for:

- Ensure worker, supervisor and other parties involved understand what to except and they all maintain communication between themselves
- Assist in developing of individualized RTW plans and participate in reviewing job demands and compare to the worker's functional abilities. Identify barriers that prevent a return to work and determine modifications to overcome the hurdles
- Act as mediator to resolve disputes
- Evaluate the program regularly
- Maintain the confidentiality of the worker's RTW personal file

Union (where applicable)

- Provide visible support for the RTW program
- Assist with the identification of RTW accommodations
- Support the worker during the RTW process
- Ensure worker rights are protected during the RTW process

Workplace Safety and Insurance Board (WSIB) / Insurers

- Adjudicate claims in a timely manner.
- Provide medical, rehabilitation, work reintegration and dispute resolution support to facilitate the return to work process.

RTW/Disability Management committee

- Assist in the development of policies and procedures for the RTW program.
- Monitor the performance of the RTW Program, making recommendations for continuous improvement.

Procedures

Return to Work Planning

- The supervisor and RTWC will arrange a joint meeting with the worker and the union (where applicable) to:

- Confirm the functional abilities to determine whether the worker can return to their regular job
- Identify and discuss the job duties the worker believes they can perform and any barriers regarding the job duties/tasks they feel unable to complete due to their injury/illness
- Obtain input from the workplace parties (worker, union and supervisors) regarding possible accommodations as necessary.

<u>Determine and analyze accommodation options and factors:</u>

- Type of accommodation - temporary or permanent?
- Health and safety – does the accommodation place the worker or co-workers at risk?
- Complexity of the accommodation – will a third-party assessment or installation be required? How long will it take to put in place? Will training for the worker and coworkers be required?
- Suitability – will the accommodation render the work safe, suitable and sustainable? Are the duties productive, consistent with the worker's functional abilities and does it restore their pre-injury/illness earnings to the greatest extent possible

Resources required

- have all parties been included and budget requirements been considered and approved? Have all sources of funding been considered up to the point of undue hardship and/or are there alternative means including internal resources that can build/install the accommodations if within their abilities (i.e. engineering, maintenance, etc.)?
- Collaborate throughout the meeting(s) to reach agreement on the best option or options based on the outcome of the discussion and analysis of removal of barriers and hazards
- Develop a progressive plan for RTW with input from all parties.

-Note: RTWC will ensure the worker is able to travel safely to the meeting and offer assistance in making travel arrangements if needed while ensuring that the meeting location is accessible as per the worker's needs as required.

- If the worker requires accommodation(s) a Return to Work Plan will be developed and documented on the Return to Work Plan Form. The plan must be mutually agreed

upon and signed by the worker, the supervisor and the RTWC. Where there is disagreement, follow the Dispute Resolution Process.

- If the RTW plan cannot be developed due to the workers functional abilities, the RTWC or supervisor to monitor the recovery and functional abilities until such time as the worker can safely participate in RTW activities.
- If the workplace parties are unable to agree on a RTW plan, or arrange a joint meeting to discuss RTW with the worker, the dispute resolution process outlined below will be followed. • In the event that a meeting to discuss modified work cannot be scheduled with the worker for any reason, a RTW Plan may be developed by the RTWC and the supervisor. The RTWC will send a Modified Work Offer Letter and a copy of the proposed RTW Plan to the worker by registered mail.

For occupational disabilities, the RTWC will advise the WSIB of the offer, and the worker's response.

<u>The RTW Plan will specify:</u>

- time frames,
- functional abilities/limitations,
- identification and description of suitable tasks in detail,
- accommodations required,
- responsibilities, and
- emergency evacuation requirements (if applicable).

Dispute Resolution Process

In situations where there are concerns or disputes related to the RTW Plan or process, the workplace parties will use the following procedure.

- Disputes may arise from, but are not limited to:
  - suitability of assigned tasks, tools or equipment,
  - functional and cognitive abilities,
  - lack of progression of recovery, and
  - safety concerns.
- The resolution of disputes will be addressed in the following manner:
  - Worker must notify the Supervisor or the RTWC of the concern or dispute. The worker is encouraged to identify potential solutions. Concerns/disputes will be documented on a Progress Report Form.

- The Supervisor will investigate the concern and discuss possible solutions with the worker. If both parties agree, the solution is implemented and the RTW Plan is updated.
- If the concern is not resolved, the Supervisor must notify the RTWC.
- The RTWC investigates the concern and considers possible solutions with the worker, the Supervisor and the union representative (where applicable).
- If all parties agree, the solution is implemented and the RTW Plan is updated

- The dispute resolution process may require the RTWC to:
  - Seek clarification or input from the worker's health care professional(s)
  - Seek clarification or input from the WSIB or STD/LTD Case Manager
  - Refer the worker for an independent medical examination (IME)
  - Refer the worker for a functional ability evaluation (FAE) or cognitive abilities evaluation.
  - Request an ergonomic assessment.
  - Request a referral to a WSIB RTW Specialist or Work Transition Specialist to facilitate a resolution (occupational cases only)
  - if the worker's concern or dispute is not resolved, the worker may:
  - Pursue an appeal with the WSIB or STD/LTD insurer
  - Initiate a grievance (unionized workers only)
  - Pursue a complaint with the Ontario Human Rights Commission, WSIB-RTW Specialist, WSIB Appeal, 3rd Party Mediation

Program Evaluation:

- The RTWC will prepare and present an annual RTW Program evaluation report to senior management and the RTW Committee that includes the following information:
  - total number of WSIB claims
  - total number of WSIB lost time days
  - total number of accommodated days for occupational disabilities
  - total accommodation costs including benefit costs paid by employer
  - the total number of RTW plans resulting in the following outcomes
  - regular duties with no accommodation
  - regular duties with accommodation
  - alternate job with no accommodation
  - alternate job with accommodation, or

- leave of absence
- summary of supervisor suggestions for program improvement
- summary of worker suggestions for program improvement
- recommendations for program improvement
- recommendations for budget allocation.

The senior management team, in collaboration with the RTWC and the RTW Committee will establish a budget for the RTW Program, develop objectives for continuous improvement and implement an action plan that includes:

- defined objectives,
- assignment of responsibilities for each objective,
- target dates for completion.

Dated at _____this _____ day of _____, 20___.

_____ _____

Signature **Witness**

_____ _____

Name & Title (please print) **Name**

Continuous Improvement Review Tracking		
Date of Review/Change	**Notes**	**Name of Reviewer**

Document 1: Functional Abilities Form

wsib ONTARIO

Mail to: 200 Front Street West Toronto ON M5V 3J1
or Fax to: 416 344-4684 OR 1-888-313-7373

Please PRINT in black ink

FAF

Functional Abilities Form
for Planning Early and Safe Return to Work

Start >

Claim No.

A. Section A to be completed by the employer and/or worker.

Worker's Last Name | First Name | Telephone

Address (no., street, apt.) | City/Town | Province | Postal Code

Employer's Name

Full Address (No., Street, Apt.)

City/Town | Prov. | Postal Code

Date of Birth (dd/mm/yyyy)

Date of Accident/ Awareness of Illness (dd/mm/yyyy)

Employer Telephone

Employer Fax No.

1. Type of job at time of accident (where available, please attach description of job activities) | Area(s) of injury(ies)/illness(es)

2. Have the worker and the employer discussed Return To Work ☐ yes ☐ no | If no, will be discussed on dd mm yyyy

3. Employer contact name | Position

B. Worker's Signature

By signing below, I am authorizing any health professional who treats me to provide me, my employer and the Workplace Safety and Insurance Board (WSIB) with information about my functional abilities on the WSIB's "Functional Abilities for Planning Early and Safe Return to Work" form.

Signature | Date dd mm yyyy

C. Health Professional's Billing Information
For billing purposes fax or mail pages 2 and 3 to the WSIB.

Health Professional's Designation
☐ Chiropractor ☐ Physician ☐ Physiotherapist ☐ Registered Nurse (Extended Class) ☐ Other

PROVIDER BILLING INFORMATION IN THE BOLDED AREA OF SECTION C SHOULD NOT BE PROVIDED TO THE WORKER OR EMPLOYER.

Are you registered with the WSIB? ☐ yes Please enter the **WSIB Provider ID.** in the box provided ☐ no Please call **1 - 800-569-7919** to register

WSIB Provider ID.

Your Invoice Number

Service Code **FAF**

▼ Complete these fields if **HST** is applicable to this form ▼

HST Registration Number | Service Code **ONHST** | HST Amount Billed **$** .

Health Professional's Name (please print)

Address (No. Street, Apt.)

City/Town | Province | Postal Code | Fax

I hereby declare that the information being submitted in Sections C, D, E and F of this form is true and complete. It is an offense to knowingly make a false or misleading statement or representation to the WSIB.

Health Professional's Signature | Telephone | Date dd mm yyyy

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...go to next page

1496 × 1936

Document 2: Return-to Work-Plan

RETURN TO WORK PLAN

Worker Name:		Worker Phone No.:	
Occupation:		Department:	
Supervisor Name:		Supervisor Phone No.:	
Date of Injury/Disability:		Claim No. (WSIB, STD, LTD):	
Plan Start Date:		Plan End Date:	

FUNCTIONAL AND COGNITIVE LIMITATIONS

List limitations provided by health care professional:	Date of Functional Abilities Form:

RETURN TO WORK PLAN

Regular Job w/accommodation ☐	Transitional Work ☐	Alternate Job ☐	Alternate Job w/ accommodation ☐

Describe assigned job duties, tasks and accommodations required (include required tools, equipment and training).
Include emergency evacuations plans if required:

RETURN TO WORK SCHEDULE

Work Week		Days and Hours Scheduled							Comments
From	To	S	M	T	W	T	F	S	

Continued next page

TREATMENT SCHEDULE		
Appointment Date	Appointment Time	Comments

MONITORING SCHEDULE	
Supervisor/Worker/Review Dates	RTWC/Supervisor/Worker Review Dates
*Updated Functional Abilities Form is required on:	

Worker Signature		Date:
Supervisor Signature		Date:
RTWC Signature		Date:

Document 3: Contact Log

Return to Work Contact Log

Worker Name:		Worker Phone No.	
Occupation:		Department	
Supervisor Name:		Supervisor Phone No.	
Date of Injury/Disability:		Claim No. (WSIB, STD, LTD)	
WSIB Contact:		WSIB Contact No.	
STD/LTD Contact:		STD/LTD Contact No.	
RTWC Name:		RTWC Contact No.	
Health Care Professional Name:		Health Care Professional Phone No.	

DATE OF CONTACT	METHOD OF CONTACT	COMMENTS

Document 4: Return to Work Progress Report

RETURN TO WORK PROGRAM – PROGRESS REPORT FORM

Worker Name:		Department:	
Occupation:		Supervisor Name:	
Date of Injury/Disability:		Claim No. (WSIB, STD, LTD):	
Plan Start Date:		Plan End Date:	

Week # Review Period (From/To Date):

DATES AND HOURS WORKED						
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Accommodations:

Duties Assigned:

Comments, Concerns and Observations:

Worker:

Supervisor/Manager:

RTWC:

Actions to Address Concerns

Next Steps:

☐ Continue with current Return to Work Plan ☐ Revise existing Return to Work Plan ☐ Close Return to Work Plan

Worker Signature		Date:
Supervisor Signature		Date:
RTWC Signature		Date:

Document 5: Physical and Cognitive Demands Analysis

- *Created as per the job positions of the Organization*
- *Below is an template of PDA*

Task Element	**0**		
Task Photo			**Description and Comments**
	Task Duration		
	Task Frequency	0	
		Enter data	
		Choose Option	

Physical Demand	*Frequency*	*Weight (kg)*	*Start Height (cm)*	*End Height (cm)*	*Hand(s) Used*	*Horizontal Reach (cm)*	*Grip Type*	*Comments*
Lift/Lower								
	Frequency	*Weight (kg)*	*Height (cm)*	*Distance (m)*	*Hand(s) Used*	*Horizontal Reach (cm)*	*Grip Type*	*Comments*
Carry								
	Frequency	*Average Force (kg)*	*Maximum Force (kg)*	*Height (cm)*	*Distance (m)*	*Hand(s) Used*	*Grip Type*	*Comments*
Push								
	Frequency	*Average Force (kg)*	*Maximum Force (kg)*	*Height (cm)*	*Distance (m)*	*Hand(s) Used*	*Grip Type*	*Comments*
Pull								
	Frequency	*Height (cm)*	*Horizontal Reach (cm)*	*Hand(s) Used*				*Comments*
Reach								
	Frequency	*Force (kg)*	*Height (cm)*	*Direction*	*Hand(s) Used*	*Horizontal Reach (cm)*	*Grip Type*	*Comments*
Grip								

	Frequency	*Force (kg)*	*Height (cm)*	*Direction*	*Hand(s) Used*	*Horizontal Reach (cm)*	*Comments*
Pinch							
	Frequency	*Duration (mins)*	*Height (cm)*	*Surface*	*Tool Type*		*Comments*
Write							
	Frequency	*Duration (mins)*	*Height (cm)*	*Finger(s) Used*	*Hand(s) Used*	*Precision Level*	*Comments*
Fine Finger Movement							
	Frequency	*Seat Height (cm)*	*Dimensions*	*Surface*			*Comments*
Sit							
	Frequency	*Surface*	*Footwear*				*Comments*
Stand							
	Frequency	*Distance (m)*	*Surface*	*Footwear*			*Comments*
Walk							
	Frequency	*Duration (mins)*	*Knee(s) Used*	*Surface*			*Comments*
Kneel							
	Frequency	*Duration (mins)*					*Comments*
Crouch/Squat							
	Duration (mins)	*Leg(s) Used*	*Surface*				*Comments*
Balance							
	Frequency	*Duration (mins)*	*Distance (m)*	*Surface*			*Comments*
Crawl							
	Frequency	*Duration (mins)*	*Distance (m)*	*Surface*			*Comments*
Climb							
	Frequency	*Food(s)*	*Precision Level*				*Comments*
Taste							

	Frequency	*Odor Type (s)*	*Precision Level*				*Comments*
Smell							
	Frequency	*Information*	*Level of Detail*				*Comments*
Speech							
	Frequency	*Duration (mins)*	*Sound(s)*	*Sound Level*			*Comments*
Hear							
	Frequency	*Duration (mins)*	*Sound(s)*	*Sound Level*			*Comments*
Feel/Tactile							
	Frequency	*Information*	*Level of Detail*				*Comments*
Vision/Read							
	Frequency	*Information*	*Technology*	*Hand(s)*			*Comments*
Data Entry							
	Frequency	*Hand Height (cm)*	*Vehicle*	*Surface*	*Surroundings*		*Comments*
Driving							
	Frequency	*Force (kg)*	*Height (cm)*	*Object*	*Foot/Feet*		*Comments*
Foot Action							
	Frequency	*Duration (mins)*	*Weight (kg)*	*Height (cm)*	*Object*		*Comments*
Handling of Odd Objects							

Document 6: Letter to Health Care Practitioner

Letter to Health Care Professional

(Date)
(Health Care Professional's
name and address)
Subject: (Worker's name and date of injury/illness)
Insurer's claim number:

Dear (Name of Health Care Professional):

Our company understands the importance of keeping workers with an injury or illness connected to the workplace by avoiding prolonged absences from one's normal roles, which is detrimental to a person's mental, physical and social well-being. We would like to work together with you and your patient [Name of worker], to help him/her return to safe and suitable work.

Our primary goal is to return our employees to their pre-injury work; however this isn't always possible. (Company name] provides a Return to Work (RTW) Program that meets the individual needs and functional abilities of our employees .The program encourages input from the employee to support in returning safely to suitable work as soon as possible. We work directly with our employees, to explore accommodation options and identify which duties or activities may need to be modified. A RTW Plan may involve making temporary or alternative work arrangements performing a variety of suitable activities.

We will consider re-arranging work schedules around medical appointments if necessary.

To facilitate our employee's return to work, please provide the functional abilities information in as much detail as possible to assist us with developing a safe and suitable return to work plan.

If you wish to receive a copy of the return to work plan, we would be happy to provide you with one. We will monitor [Name worker]'s progress throughout the duration of the return to work plan.

If you require additional information about a possible work assignment or about our return to work program, please do not hesitate to contact me.

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

Sincerely,

(Return to Work Coordinator Name), Job Title
(Name of Company)
(Phone Number)

Doucment 7: Modified Work offer letter to injuried/ill person

(Date)
(Worker name)
(Worker address)
(City, Province)
(Postal Code)

Re: Modified Work Offer

Dear (Worker first Name):

Thank you for your input on your return to work. As we discussed, you have agreed the temporary assignment we reviewed and offered is within your capabilities. This letter confirms our job offer and proposed Return to Work (RTW) Plan. Please see the attached RTW Plan for details.

Job Title:
Location:
Duration of Assignment:
Wages:

Department:

(Insert the following paragraph for occupational injuries/illnesses only):

I wish to remind you of your responsibilities under the Workplace Safety and Insurance Act and **Policy 19-02-02 Responsibilities of the Workplace Parties in Work Reintegration**

Together with your employer, you are required to cooperate in all aspects of the return to work process including:

- initiating early contact
- maintaining appropriate communication
- helping to identify and secure return-to-work opportunities
- providing the WSIB all relevant functional abilities information to help plan the return-to-work
- notifying the WSIB of any return to work dispute or disagreement

This temporary assignment is available immediately. We look forward to collaborating with you to help you return to suitable and sustainable work.
Please do not hesitate in contacting me directly with any questions or if you are experiencing difficulties with your RTW Plan.
Please note that a copy of this letter has been provided to the WSIB/Insurance carrier.
We look forward to your return.

Sincerely,

(Printed Name)
Return to Work Coordinator/Job Title
(Contact Information)

Doucment 8: Medical Consent for release of Information

To Whom It May Concern,
RE: [Worker's name] Claim number:

In order to identify my functional abilities, and whether I have any restrictions or limitations that will need to be accommodated in order to help me remain at, or return to work:

I, [worker's name], authorize [RTWC name, position and company], to contact [insert name of health care professional] in order to:

- request completion of a Functional Abilities Form;
- obtain a copy of a completed Functional Abilities Form; and/or
- obtain clarification with respect to the restrictions, limitations and/or the duration of restrictions or limitations identified on a Functional Abilities Form.

For the purposes of developing, implementing or seeking approval of a return-to-work plan, and to identify any accommodation measures that may be required, my functional abilities information may be shared among:

- my supervisor/manager; the unit/local Return to Work Committee (if applicable); the appointed Return to Work Coordinator; or authorized human resources officer; or
- my insurer (occupational or non-occupational) if applicable.

Worker's name: (please print)
Address:
Home Tel:
Work Tel:
Signature:
Date:

Witness name: (please print)
Address:
Home Tel:
Work Tel:
Signature:
Date:

Doucment 9: Retunr-to-Work Plan Closure and Evalution feedback froms

RETURN TO WORK CLOSURE EVALUATION REPORT-WORKER

Worker Name:		Department:	
Occupation:		Supervisor Name:	
Date of Injury/Disability:		Claim No. (WSIB, STD, LTD):	
Plan Start Date:		Plan End Date:	

Select the final outcome of the Return to Work Plan:

- ❑ Returned to regular job
- ❑ Returned to regular job with accommodation
- ❑ Returned to an alternate job
- ❑ Returned to an alternate job with accommodation
- ❑ Applied for STD/LTD benefits
- ❑ Applied for WSIB benefits
- ❑ Retraining – STD/LTD Insurer
- ❑ Retraining - WSIB

QUESTION	YES	NO	N/A
1. Did the Return to Work Coordinator provide information regarding benefits and services available under the company's benefits and RTW programs? Comments:	❑	❑	❑
2. Did you experience any challenges or concerns with your RTW Plan? Comments:	❑	❑	❑
3. Did your supervisor resolve your concerns with the RTW Plan in a timely manner? Comments:	❑	❑	❑

Continued next page

QUESTION	YES	NO	N/A
4. Did the Return to Work Coordinator resolve your concerns with the RTW Plan in a timely manner? Comments	❑	❑	❑
5. In your opinion, was your supervisor supportive of your Return to Work Plan? Comments	❑	❑	❑
6. In your opinion, were your co-workers supportive of your Return to Work Plan? Comments	❑	❑	❑
7. Was your overall experience with the RTW program positive? Comments	❑	❑	❑
8. Do you have any suggestions to improve the company's Return to Work program? Comments:	❑	❑	❑

Worker Signature:	Date:

Thank you for providing valuable feedback on your experience with the Return to Work Program. Your feedback will be used to improve the company's Return to Work Program.