Medical Release Information

I, _____ hereby release my treating physician, _____
,

Print Name Print Physician's Name

to give my employer, pertinent information about my current work-related injury/illness and how that injury may affect my ability to perform the essential functions of my job. No other confidential medical information may be released without my written consent. This release will be valid no longer than 90 days, at which time it will be re-evaluated. Any medical information obtained will only be used in the return-to-work program, and there will be no release of medical information from the employer's file.

_____ _____

Injured Employee's Signature Date

_____ _____

Employee's Signature Date

Policy Statement for the Return-to-Work Process

Company's name is committed to providing and promoting a safe and healthy workplace for our employees. Preventing accidents, injuries and illnesses is our primary objective.

When an employee is injured on the job, Company's name will use our return-to-work process to assist the employee in returning to work as soon as medically feasible. We will arrange for immediate, appropriate medical attention for employees who are injured on the job. We will attempt to create opportunities for them to return to a safe, transitional work assignment as soon as medically possible.

The process may have different names (return-to-work program, modified work program, transitional work); however, our goal remains the same: to return injured employees to safe work.

Our ultimate goal is to return our injured employees to their original jobs. If an injured employee is unable to perform all the tasks of the original job, Company's name will make every effort to provide a transitional work assignment that meets the injured worker's capabilities.

The success of this process involves the combined efforts of management, employees, our designated medical provider and our workers' compensation insurance carrier.

_____

President/ CEO

Rev 07/2014

Date

Notification of Transitional Work Assignment

Employee's Name
Address
City, State Zip Code

Certified Mail Return-Receipt Requested
Re: Notice of Employment under the Return-to-Work Program
Dear Employee:

Company's name has a transitional work assignment available for you until your physician releases you to a full work status in accordance with our Return-to-Work Program.

Your transitional work assignment will last until you return to regular work or until the company no longer needs you in this position: the position may be indefinite. The position is in the department where you will explain job duties. The job entails maximum physical demands of position.

Your physician, physician's name has authorized your return-to-work in this job and has agreed that this work assignment is within your physical limitations. Attached is a copy of his release. We agree to follow the advice of your physician until you are released to full duty.

Your work schedule will be hours, on days of week and you will be expected to report to location supervisor name. Your rate of pay will be $ per .

If you do not accept the offer, CopperPoint may make an adjustment in your compensation benefits based on the earnings this transitional assignment would provide.

We look forward to seeing you on MM/DD/YYYY. If you have any questions, please call us at . . .

Sincerely,

Name
Job Title
Additional Contact Info

Cc: Supervisor
Workers Compensation Insurance Claims Adjuster
HR Department
Enclosures:

I have read and understand the above information. ☐ I accept this job ☐ I decline this position

Employee's Signature _____ Date _____