Administrative Procedure: Return to Work

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1.0. Guidelines

1.1. The Return to Work Program (Return To Work) applies to all employees of the Superior North Catholic District School Board, both unionized, non-unionized, and management who require accommodation/modification of work as a result of injury or illness. The return to work program will be a collaborative and outcome based process to assess, plan, implement, coordinate, monitor and evaluate the options and services required to meet an individual's needs. Return to work case management will include a planned and organized approach to achieving an outcome for an injured or ill employee. The Superior North Catholic District School Board and it's employees are committed to cooperating and participating in their Return to Work Program.

1.2. Referral sources include a medical practitioner.

1.3. Membership of the Return to Work Plan team will comply with Collective Agreements and should include Employee, Human Resources Manager or their designate, Employee's Supervisor, and the OECTA Unit President/SEIU Local 2 Union Representative. The Superintendent of Education and/or Return to Work Specialists through WSIB and OTIP may be included depending on the seriousness of illness or injury.

2.0. Roles and Responsibilities

2.1. Board Responsibilities

2.1.1. Provide a safe and healthy work environment.

2.1.2. Educate all employees about the Return To Work program.

2.1.3. Advise employees on proper reporting of illness, incidents or accidents.

2.1.4. Promptly report work-related injuries to WSIB.

2.1.5. Regularly communicate with employees during their time away from work, and monitor their progress when they return.

2.1.6. Work with the employee and medical practitioner to identify suitable work.

2.1.7. Modify the workplace, as required to accommodate employees who are disabled due to illness or injury.

2.1.8. Monitor the progress of employees in modified work programs and meet with them regularly to ensure they will be successful in achieving their return to work goal.

2.2. Employees

2.2.1. Depending on the nature of injury or illness and the type of work that is performed, before returning to work after an injury or illness, a Functional Abilities Evaluation may be used to help determine the employee's abilities and to outline any immediate or long -term risks from resuming normal at work functions. In accordance with Collective Agreements, the employee may be referred for an Independent Medical Examination (IME) to be completed by a medical practitioner qualified in respect of the illness or injury at issue of the school board's choice.

2.2.2. Where a minor injury or accident has occurred where there has been NO LOST TIME or MEDICAL ATTENTION required, the worker will complete and submit the Board's Online Employee Incident Reporting. The Human Resources Manager will monitor these for prevention purposes.

2.3. Employee Responsibilities

2.3.1. Know and follow safety policies and procedures.

2.3.2. Report any injury or illness immediately.

2.3.3. If medical attention is necessary, inform your medical practitioner that return to work opportunities are available to accommodate functional abilities.

2.3.4. Communicate with the Board through your recovery period, and cooperate with the Board in finding suitable employment for your return to work.

2.3.5. Take an active role in developing your return to work plan.

2.3.6. Obtain the necessary documents from the treating medical practitioner, as may be required by the Board (for example, functional abilities information).

2.3.7. Return to work as directed by a medical practitioner.

2.3.8. Report any concerns with your return to work to your supervisor, human resources manager and your WSIB return to work specialist or OTIP (if applicable) so that problems can be addressed promptly.

2.4. WSIB Responsibilities

2.4.1. Ensure the proper administration of all claims.

2.4.2. Maintain communication with the Board, and the injured employee and their medical providers.

2.4.3. Offer mediation services when a dispute arises regarding return to work.

2.4.4. Help the Board and their injured employees, when necessary, through the return to work process.

2.4.5. Determine the suitability of employment and fitness to return to work.

2.4.6. Encourage and actively assist injured workers in their successful return to work.

2.5. Human Resources Manager or designate Responsibilities

2.5.1. Act as a central point of contact to communicate and coordinate the return to work process with all involved parties such as employee, union, supervisors, medical practitioners , and the insurance provider.

2.5.2. Develop individual Return To Work Plans along with the principal/supervisor with input from the injured/ill employee and facilitate workplace support for the Return To Work program.

2.5.3. Monitor the progress of each return to work case and advise all involved parties of any changes to wages, duration or duties of the plan and the closure of the plan.

2.5.4. Document all activities and responsibilities in each return to work case and oversee the administration of the return to work program.

2.6. Supervisor/Principal

2.6.1. Investigate the accident (as per Board procedure).

2.6.2. After the injured employee's first aid needs are met, encourage the employee to fill the Board's Online Employee Incident Reporting Form.

2.6.3. If medical attention is necessary, remind the employee to fill out WSIB form 6 and their medical practitioner to fill out WSIB form 8.

2.6.4. Cooperate with the Employee, Medical Practitioner, Human Resources Manager or designate and the Union in finding alternate work for the injured worker.

2.6.5. Monitor and evaluate the injured employee's performance during the period working under the Return to Work Plan.

2.6.6. No change to the Return to Work Plan will occur without support from the employee's medical practitioner.

2.7. Union Representative Responsibilities

2.7.1. Participate, support and guide the employee in understanding the Return To Work procedures, responsibilities and support where required in the return to work plan.

2.7.2. Participate in the return to work meetings.

2.8. 2.8 Medical Practitioner Responsibilities

2.8.1. Provide appropriate, effective health care that facilitates recovery and expedites return to productive work.

2.8.2. Provide information on the injured or ill worker's functional abilities when requested by the Board, the employee or WSIB.

2.8.3. Provide timely information to WSIB.

2.8.4. Provide necessary treatment and refer employee to community and regional rehabilitation clinics and health care specialists as appropriate, in a timely manner.

3.0. Reporting Requirement WSIB

3.1. Employees will report all occupational injury and illness immediately to the Supervisor/ Principal.

3.2. The Employee will complete a report of the injury/illness immediately and submit to WSIB and provide a copy of the Form 6 to the Human Resources Manager or designate.

3.3. The Human Resources Manager or designate will complete a report of the injury/illness and submit to WSIB within three (3) days and provide a copy of the Form 7 to the injured employee within seven (7) days.

4.0. Reporting Requirement Non-WSIB

4.1. Employees will report all injuries and illness immediately to the Supervisor/Principal.

4.2. Injury/illness of eleven (11) consecutive days or more, the Human Resources Manager or designate will establish a contact schedule with the injured employee through the recovery period and arrange regular meetings with all parties such as the employee, union, supervisors; with results from the Board's Medical Certificate Form 1 to determine the injury/illness employee level of functional abilities and ability to participate in accommodated work.

5.0. Eligibility and Referral to the Return To Work Program

5.1. Employees are referred to the Return To Work program when they are unable to do their regular job due to a medically determined physical or mental impairment caused by an illness or injury for which they are actively seeking active treatment and that is substantiated with medical evidence. All occupational injuries/illnesses will be managed by the Human Resources Manager or designate.

5.2. The Human Resources Manager or designate, Supervisor and Employee will agree to the modified work plan using the Superior North Catholic District School Board's Modified Work Plan Agreement, Form 2. If the parties do not agree, then procedures outlined in Collective Agreements will be followed.

6.0. The process for the Return To Work Accommodation

6.1. Upon receipt and review of the Board's Medical Certificate form and/or the Functional Abilities Evaluation, the Human Resources Manager or designate and the supervisor will review job accommodation options with input from the injured/ill employee and the union. Accommodations may require an adjustment of the work process, work schedule or a formal modification to the workstation up to and including assistive devices (as long as it does not constitute undue hardship for the Board).

6.2. The principal or supervisor will monitor the progress of the accommodation using the Superior North Catholic District School Board Modified Work Program Progress Report, Form 3.

6.3. The employee will communicate any concerns or issues to their supervisor and Human Resources Manager or designate so that changes or adjustments can be made to support a successful completion of the return to work plan with support from the employee's medical practitioner.

7.0. Review

7.1. 7.1 The Human Resources Manager or designate will review this procedure within three years, to ascertain if any amendments are required. OECTA and SEIU Local 2 will be asked to share their input, for consideration based on the date on the Return to Work Policy.

APPENDIX A

Form 1 - SNCDSB's Medical Certificate Form

This form shall be provided by the medical practitioner to the employee who will then deliver it to the Human Resources Department.

Medical Certificate

Absent from Work

_____ _____ _____
(first date of absence)

☐ Not absent from work but requires accommodations

Part 1 – Employee - please complete following:

_____
(Employee Name)

The information supplied will be used in a confidential manner and may assist in creating a return to work plan.

I hereby consent to the completion of this form by:

_____
(Treating Medical Practitioner's Name)

Signature of Employee

_____ Date: _____ _____ _____
(dd/mm/yyyy)

Part 2 – Medical Practitioner – please complete the following

1. Nature of Illness *(do not provide diagnosis):*

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* "Nature of the illness"(or injury) suggests a general statement of a person's illness or injury in plain language without any technical medical details, including diagnosis or symptoms. Although revealing the nature of an illness may suggest the diagnosis, it will not necessarily do so. "Nature of illness" and "diagnosis" are not congruent terms. For example, a statement that a person has a cardiac or abdominal condition or that s/he has undergone surgery in that respect reveals the essence of the situation without revealing a diagnosis.

2. Is this condition the result of: *(check one)*

☐ Non-occupational illness/injury ☐ Occupational illness/injury

3. Is he/she receiving treatment: ☐ Yes ☐ No

4. Has or will a referral to a specialist been made? ☐ Yes ☐ No

If yes, date of referral: _____ _____ _____
(dd/mm/yyyy)

5. Have you discussed return to work with your patient? ☐ Yes ☐ Not at this time

6. Is the patient able to return to work: ☐ with accommodation ☐ without accommodation

Expected date of return: _____ _____ _____
(dd/mm/yyyy)

☐ unable to return to work at this time

7. Date of next assessment: _____ _____ _____
(dd/mm/yyyy)

Health Care Practitioner Signature:

Date Completed: _____ _____ _____
(dd/mm/yyyy)

Health Care Practitioner Name and Address:

Part 3 and/or 4 need only be completed for a return to work that requires an accommodation.

Part 3 – Medical Practitioner – please complete the following:

COGNITIVE LIMITATIONS AND/OR RESTRICTIONS ☐ **N/A**				
Please describe cognitive limitations and/or restrictions. Physical limitations and/or restrictions, if any, can be detailed in Part 4. These cognitive restrictions will be assessed when determining modified work either in the employee's own position or another suitable position.				
Date of Assessment: _____ _____ _____ *(dd/mm/yyyy)*				
Level of Functioning *(Please circle which level applies for each task)*	☐ **LEVEL 1**	☐ **LEVEL 2**	☐ **LEVEL 3**	☐ **LEVEL 4**
Supervision Required	☐ needs constant supervision	☐ needs frequent supervision	☐ needs limited supervision	☐ requires no supervision
Supervision of Others	☐ not able to supervise others	☐ can meet demands of or for occasional supervision	☐ can meet demands of or for regular supervision	☐ can meet demands of full supervision
Tolerance to Deadlines	☐ cannot deal with deadline pressures	☐ occasionally deal with deadlines	☐ can deal with deadlines that are reoccurring	☐ can deal with strict deadlines
Attention to Detail ***(indicate maximum time the Individual can concentrate)***	☐ concentration on detail is severely limited	☐ concentrate on detail is limited	☐ can concentrate on details, needs occasional breaks of non detailed work	☐ able to concentrate intensely on detailed work
Performance of Multiple Tasks	☐ can deal with one task at a time	☐ can handle more than 1 task but requires cues as to when to do task	☐ can handle multiple tasks requires some time management assistance	☐ fully able to handle multiple tasks without difficulty
Tolerance to External Stimulus	☐ needs quiet, non distracting work environment	☐ can cope with small degree of distraction	☐ can cope with distracting stimuli for portion of day	☐ fully able to cope with multiple stimuli without negative effect
Ability to Work with Others Cooperatively	☐ tolerates working alone	☐ can cope with exposure to confrontational situations with back-up available	☐ can work with others cooperatively when required	☐ fully able to work in close cooperation with others
Confrontational Situations	☐ unable to cope with confrontational situations	☐ can tolerate others within vicinity, but needs to perform independent tasks	☐ moderate ability to cope with confrontational situations	☐ able to deal with confrontational situations with tact and control
Responsibility and Accountability	☐ errors in judgment or attention likely to occur	☐ can exercise a moderate level of responsibility with occasional need for support	☐ can accept responsibility including the responsibility for the safety of others	☐ can accept a high level of responsibility including sensitive situations

COGNITIVE LIMITATIONS AND/OR RESTRICTIONS

Prognosis (based on objective assessments)
From the date of this assessment, the above will apply for approximately:

☐ **1-2 weeks** ☐ **3-5 weeks** ☐ **6-8 weeks** ☐ **2-3 months** ☐ **4-6 months** ☐ **6+ months** ☐ **Unknown**

Recommendations for work hours and start date:

☐ **Regular full time hours**
☐ **Modified hours**
☐ **Graduated hours**

Start Date: _____ _____ _____
(dd/mm/yyyy)

Next appointment date to review Limitations and/or Restrictions: _____ _____ _____
(dd/mm/yyyy)

Part 4 - Medical Practitioner – please complete the following:

PHYSICAL LIMITATIONS AND/OR RESTRICTIONS ☐ N/A

Please describe physical limitations and/or restrictions only. Cognitive limitations and/or restrictions, if any, can be detailed in Part 3. These physical restrictions will be assessed when determining modified work either in the employee's own position or another suitable position.

Date of Assessment: _____ _____ _____
(dd/mm/yyyy)

Walking:	Standing:	Sitting:	Lifting from floor to waist:
☐ Full abilities ☐ Up to 100 metres ☐ 100 - 200 metres ☐ Other (please specify) _____	☐ Full abilities ☐ Up to 15 minutes ☐ 15 - 30 minutes ☐ Other (please specify) _____	☐ Full abilities ☐ Up to 30 minutes ☐ 30 minutes - 1 hour ☐ Other (please specify) _____	☐ Full abilities ☐ Up to 5 kilograms ☐ 5 - 10 kilograms ☐ Other (please specify) _____

Lifting from Waist to Shoulder:	Stair Climbing:		
☐ Full abilities ☐ Up to 5 kilograms ☐ 5 - 10 kilograms ☐ Other (please specify) _____	☐ Full abilities ☐ Up to 5 steps ☐ 5 - 10 steps ☐ Other (please specify) _____		

PHYSICAL LIMITATIONS AND/OR RESTRICTIONS

☐ Bending/twisting repetitive movement of *(please specify):*	☐ Work at or above shoulder activity:	Limited pushing / pulling with:	Limited use of hand(s):
		☐ Left Arm ☐ Right Arm ☐ Other (please specify)	Left / Right ☐ ☐ Gripping ☐ ☐ Pinching ☐ ☐ Other

Other (Please describe)

Prognosis (based on objective assessments)
From the date of this assessment, the above will apply for approximately:

☐ **1-2 weeks** ☐ **3-5 weeks** ☐ **6-8 weeks** ☐ **2-3 months** ☐ **4-6 months** ☐ **6+ months** ☐ **Unknown**

Recommendations for work hours and start date:

☐ **Regular full time hours**
☐ **Modified hours**
☐ **Graduated hours**

Start Date: _____ _____ _____
(dd/mm/yyyy)

Next appointment date to review Limitations and/or Restrictions: _____ _____ _____
(dd/mm/yyyy)

Please provide any additional information/comments/findings/limitations (ex. Physical, Cognitive) which you feel would assist our employee in a safe and timely return to work.

APPENDIX B

Form 2 - SNCDSB's Modified Work Plan Agreement

Employee Name: _____

Date of Injury: _____ _____ _____

School: _____

Nature of Injury: _____

Position: _____

Last Day Worked: _____ _____ _____

Supervisor: _____

Modified Job Description:

_____

Days/Hours: Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat. ☐

Site Assigned To: _____

Duties:

_____

Date to Commence Modified Plan: _____ _____ _____

Anticipated Date To Complete Modified Work Plan: _____ _____ _____

Pro-Rating of Sick Leave During Term of Work Plan: _____

I, _____ agree to participate in this Modified Work Plan.

(Name of Employee)

Signature of Employee:

☐ Date: _____ _____ _____

Signature of Supervisor:

☐ Date: _____ _____ _____

Signature of HRM or designate:

☐ Date: _____ _____ _____

APPENDIX C

Form 3 - SNCDSB's Modified Work Program 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 _____

Position: _____

Week #: _____

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, list concerns 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 Recommendations/Comments:

WSIB
(Workplace Safety and Insurance Board)
Ontario

Worker Forms on WSIB

eForm 6 - Worker's Report of Injury/Disease

Employer Forms on WSIB

https://www.wsib.ca/en/eform-7

"The online version of our Form 7 (Report of Injury/Illness) is the fastest way to report a workplace injury or illness. The online version of the form lets you bypass pre-populated and default fields, and you'll receive an immediate confirmation of your submission and electronic notice of any status changes. You can also upload and immediately submit any relevant documents straight to the appropriate claim file." Quoted from WSIB's website.