GEORGIA SOUTHERN UNIVERSITY

HUMAN RESOURCES POLICIES AND PROCEDURES

Area: Employee Benefits	Number:	2450
Subject: Return to Work	Issued:	7/2008
Applies To: Georgia Southern University Employees	Revised:	
Sources:	Page(s):	1 of 10

Purpose

Georgia Southern University encourages employees to return to work following a work-related injury or illness. If an employee is able to work, but is unable to return to his or her regularly assigned duties, this program is designed to transition an employee to work in a modified or alternative assignment.

Policy

Georgia Southern University provides a return-to-work program for work-related injuries or illnesses as the means to return or transition employees to meaningful, productive employment following the injury or illness.

Procedure

1.1 The return-to-work program provides opportunities for any Georgia Southern University employee covered by workers' compensation insurance who sustains a compensable injury or illness during the course of employment, to return to work at partial or full duty.

If the employee is not physically capable of returning to full duty, the return-to-work program provides opportunities for offering the employee a temporary assignment in which the employee's regular position is modified to accommodate the employee's physical capacities, or to perform a transitional assignment with alternate duties. Assignment of any employee to a transitional position or modified regular position in accordance with the return-to-work program, including determination of the pay rate for the transitional position, requires review and approval from the human resources department. In the case of a faculty member, the human resources department will work with Vice President for Academic Affairs to determine appropriate transitional work and compensation.

1.2 This return-to-work program shall not be construed as recognition by the university, its management, or its employees that any employee who participates in the program has a disability as defined by the Americans with Disabilities Act of 1990. If an employee sustains an injury or illness resulting in a disability under the Americans with Disabilities Act, it is the employee's responsibility to inform his or her supervisor or a person in a responsible management position when a disability under the Americans with Disabilities Act exists and that a reasonable accommodation is necessary to perform the essential functions of his or her job.

1.3 As soon as the employee is released to return to work activities, the employee will be asked to meet with the supervisor to determine if the employee can return to his or her regular duties. If the employee cannot immediately return to his or her regular duties, the employee may be given a special or transitional assignment as follows:

a. Assignment to the employee's regular position with temporarily modified duties designed for an employee who is temporarily unable to function at full capacity in the regular position due to work-related illness or injury, but who is expected to return to regular duties within six months. Such duty modification requires the certification of the employee's treating physician. Once the physician certifies that an employee can return to work, the supervisor must return the employee to work and adhere to the employee's medical restrictions.

b. Return to work to a transitional position with different duties designed for employees who are temporarily unable to function at full capacity in the regular position due to work-related illness or injury, but who are expected to return to regular duties within six months. The employee must possess the knowledge, skills, and abilities required to function in the transitional position. Such temporary reassignment is to be used only when temporarily placing the employee in the transitional position would provide mutual benefits to the university and the employee, and when no current employee would be displaced by such reassignment. Such temporary reassignment requires the certification of the employee's treating physician. Once the physician certifies that an employee can return to work, the supervisor must return the employee to work and adhere to the employee's medical restrictions.

1.4 An employee who returns to work in a special assignment may be assigned to another work site within the university, depending upon the availability of vacant positions or the limitations or abilities of the employee.

1.5 An employee will not be placed into a transitional or regular position if such an assignment would place the employee or others in danger.

1.6 An employee will not be placed into a position if such assignment would displace another current employee.

1.7 An employee in a special, transitional assignment is responsible for providing periodic reports from his/her health care provider during the period of the temporary assignment.

1.8 Transitional assignments require advance approval of the human resource department. If a transitional assignment warrants a pay change for the affected employee, the human resources department is responsible for determining the correct pay rate for the transitional assignment. In the case of a faculty member the human resources department will work with Vice President for Academic Affairs to determine appropriate transitional work and compensation.

The employee's salary in the transitional assignment shall be paid by the employee's primary department. The maximum duration of a transitional assignment is six months.

1.9 Georgia Southern University complies with the Americans with Disabilities Act of 1990 which prohibits discrimination against qualified individuals with disabilities. Nothing in this program shall be used as the basis for illegal discrimination against any individual or group.

1.10 It is a violation of the return-to-work program, procedures, and state and federal law to discharge or in any other manner discriminate against an employee because he or she:

- Files a workers' compensation claim in good faith;
- Hires a lawyer to represent his or her interests in a workers' compensation claim; and/or

- Institutes or causes to be instituted in good faith a proceeding with the Georgia State Board of Worker's Compensation.

BONA FIDE OFFER OF EMPLOYMENT

2.1 Assignment to any of the types of positions described in Section 3 will be documented in a "bona fide offer of employment" letter to the employee. The bona fide offer of employment letter shall include the following information:

- The type of position offered and the specific duties.
- A statement that the university is aware of and will abide by any physical limitations under which the treating doctor has authorized the employee return to work.
- The maximum physical job requirements
- The wage of the job
- The expected assignment duration
- A statement that the university cannot guarantee that a position will be available should the employee fail to accept the assignment.
- The name of the contact person the employee can contact for answers to questions about the assignment, job modifications, or other relevant leave provisions.

2.2 The employee may accept or reject this bona fide offer of employment. The employee should be informed that rejection of the bona fide offer of employment may jeopardize continued temporary income benefits (if applicable) and would be considered job abandonment. If the employee rejects the bona fide offer of employment, then the employee remains off work without pay until the end of any approved leave period or until the employee is certified by the health care provider to return to full duty. The health care provider must complete the Reasonable Accommodation In Employment Information Form prior to the employee returning to work. Subsequently, it is the employee's responsibility to adhere to the health care provider's certification upon returning to work.

If the employee accepts the bona fide offer of employment, then the employee shall perform the duties of the position for the term of the assignment and stated by their health care provider or until the employee is able to return to full duty, whichever is sooner.

2.3 If the employee is unable to return to full duty by the end of the assignment period and/or by the end of the employee's approved leave period, then the employee's continued employment with the university shall be considered based upon the business necessity of filling the employee's position.

Georgia Southern University

Reasonable Accommodation In Employment Information Form

Please complete this form to release information regarding your request for an accommodation. Please **print** clearly and return the completed from to Human Resources (Benefits Office), P.O. Box 8104, Statesboro, GA, 30460-1804. If you have any questions, please call the Benefits Office at (912) 478-1538.

REQUESTION EMPLOYEE:

Name (First, MI, Last):	ADP ID Number:	Campus Telephone:
Current Supervisor:	Department:	Employee Home Telephone:
Reason for request (situation, length of disability, etc.):		
Job functions affected (taken from job description):		
Suggested accommodations:		

To be considered a "qualified individual with a disability" means an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such an individual holds or desires.

I have attached a certificate from a licensed health care provider which describes the illness, injury, impairment or physical or mental condition and the approximate duration of the condition if temporary. This required certificate is dated and signed by said provider. I consent to allow the Reasonable Accommodations in Employment Committee to follow up with the health care provider if necessary.

_____ _____

Employee Signature Date

For Human Resources use only: Eligible to receive “reasonable accommodation” Yes ___ No ___
Date of completed forms: _____ Date of employee review: _____ Date of supervisor review: _____ Date of committee review: _____ Date of decision notification: _____
Approved to receive “reasonable accommodation” Yes ___ No ___
Reason(s) for not approving request:
Type of “reasonable accommodation” made:

_____ _____

Signature (Human Resources) Date

Dear _____ (Health Care Provider)

We are asking for input by the attending health care provider to determine what accommodations (if any) are needed for _____(print employee name) to perform the essential functions of the attached job description. Please complete the following information and return to Human Resources (Benefits), P.O. Box 8104, Statesboro, GA 30460-1804.

I hereby authorize any doctor or medical institution having information concerning me to release said information to Georgia Southern University, or its designated representative.

Employee Signature: _____ Date: _____

Attending Physician's Statement of Functional Capacity

The information provided is to be used for evaluation and auditing purposes only. The patient is responsible for having this form completed without expense to the employer.

NAME of PATIENT: _____

1. **History and diagnosis: Please write legibly.**
    a. Date symptoms first appeared or accident occurred:
    b. Date patient ceased to work:
    c. Date of most recent examination:
    d. Frequency of visits:
    e. Past history:
    f. Subjective symptoms:
    g. Objective findings (including test results):
    h. Primary diagnosis affecting work ability:
    i. Secondary diagnosis affecting work ability:

j. Present and future course of treatment:

k. Other known injuries or presently active diseases that may affect work abilities:

2. Does the patient's medical condition allow exposure to the following? Please check appropriate category and **EXPLAIN ANY LIMITATION BELOW.**

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Allergenic agents				
Chemical / Solvents				
Drafts / Damp areas / molds				
Dust / Gases / Fumes / Fragrances				
Enclosed spaces				
Noise levels				
Scaffolds / Heights				
Stairs / Ladders				
Temperature Extremes				

Explanation:

3. Because of the patient's medical condition, are there any limitations on any of the following activities? Please check appropriate category and **EXPLAIN ANY LIMITATION BELOW.**

	No Limitation	Some Limitation	Avoid Completely	Cannot Determine
Assuming cramped / unusual positions				
Balancing (exposure to falling)				
Bending / stooping/ squatting				
Change of position (sitting/standing)				
Concentrated visual attention				
Finger dexterity				
Grasping / handling				
Operating electrical equipment				
Operating heavy equipment				
Operating truck/dolly/small vehicle				
Pushing/pulling/twisting (arm/leg controls)				
Reaching (forward/overhead)				
Repetitive movement (hands/feet)				
Sitting				
Standing				
Transportation				
Other				

Explanation:

4. Evaluation of carrying and lifting abilities includes both the intensity and frequency of the activity. For each weight class listed below, please indicate the reasonable top limit of frequency. Please provide an **EXPLANANTION BELOW** with any additional comments regarding limitations on duration, handle ability and distance (in front of body and above floor).

Intensity in pounds	Frequency: % of Never	Workday Less than 20%	20% - 60%	Greater than 60%
0 – 15				
16 – 30				
31 - 45				
Greater than 45				

Explanation:

5. If you have any additional information that is relevant to the patient's work ability as related to the attached job description, please indicate below.

6. _____I certify that the employee has a physical, mental, emotional impairment that limits one or more major life activity. The life function affected is **(circle all that apply):**

Caring for oneself, performing manual tasks, walking, seeing, hearing , sitting, speaking, breathing, learning, working, remembering, other (please describe):

Name of Health Care Provider (please print) Board Certified Specialty

Street Address	City or Town	State

Telephone number	Date	Signature