THE HOWARD COUNTY PUBLIC SCHOOL SYSTEM
10910 Clarksville Pike
Ellicott City, Maryland 21042

Circular No. 36
Series 2017-2018

December 15, 2017

Chief Human Resource and Development Officer

Procedures for Workers' Compensation and Employee Incident Reports

TO: All Staff

FROM Helen Nixon, Chief Human Resources & Leadership Development Officer

Attached please find a copy of the updated procedures for reporting a work-related injury/illness. Also, please find sample copies of the Workers' Compensation Commission First Report of Injury (Form IA-1) and Employee Incident Report, referred to in the procedures.

Please read the procedures thoroughly and, in particular, pay careful attention to what you must do when an employee assigned to your school/area is injured or assaulted. Please inform your staff of the procedures for reporting incidents and obtaining medical care. Failure to follow these procedures may impact the workers' compensation benefits received. The forms must be completed and forwarded to Human Resources within 24 hours of the injury.

Additional forms are available from the Workers' Compensation Specialist upon request and are also available on the Staff Hub under Services → Employee Resources→ Workers' Comp & Incident Reports.

If you have any questions, please contact the Office of Workers' Compensation at 410-313-7494.

JW/PM

Attachment

**Howard County Public School System**
10910 Clarksville Pike
Ellicott City, MD 21042

# Workers' Compensation

# Program and Procedures

Last Revised: 12/07/17

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# HCPSS WORKERS' COMPENSATION PROGRAM

Workers' Compensation is a program that provides benefits for an employee who sustains a compensable work related injury or illness while performing assigned job duties in the course of employment. All work related injuries/illnesses must be reported. Work related injuries/illnesses of employees are subject to the Maryland Workers' Compensation laws.

The Howard County Public School System (HCPSS) Workers' Compensation benefits and procedures are as follows:

1. Appropriate medical attention (first aid and/or professional medical care) will be provided immediately to an employee sustaining a work-related injury/illness. Professional medical care is provided through the following procedures:

    a. **Call 911 immediately for a life-threatening injury/illness**. If the employee is not admitted to the hospital, the **employee** may be directed to report to Concentra Medical Center within 24 hours of treatment from the hospital. An Employer's Authorization for work evaluation and/or treatment is to be taken by the employee to the initial visit at Concentra Medical Center. This form is to be provided (and completed) by the employee's site of employment (school or office).

    b. **Non-emergency injury/illness**. The employee may report to Concentra Medical Center, 6656 Dobbin Road, Columbia, MD 21045, 410-381-1330 or Concentra Medical Center, 7377 Washington Boulevard – Suite 101, Jessup, MD 21075, 410-379-3051 for work evaluation and/or treatment. The employee will be given an Employer's Authorization for Examination or Treatment to take to the initial visit at Concentra Medical Center. Employees may also select their own treatment center.

    c. If it is a non-emergency injury/illness, and the employee requires professional medical care after Concentra Medical Center's normal hours of operation, the employee may receive treatment from a different medical provider. The **employee** is **required** to provide a copy of the work status report at the start of the next business day following the evaluation.

2. All incidents must be reported by the employee to a supervisor immediately after the event. Any employee or individual aware of the incident may report the incident, if the injured/ill employee is unable to do so.

a. Failure to notify a supervisor of an incident may subject the employee to disciplinary action and, if applicable, the 90-day full salary benefit may be forfeited.

b. An Employee Incident/Injury Report will be completed for all incidents as soon as possible, even those that do not require medical attention. This form serves as notification of the incident, should medical attention be required at a later date.

1. The employee completes each question on Section I (front page), signs, dates the form, and returns it to the Principal/Supervisor/Lead Person.

2. Section II is completed, signed, and dated by the principal/supervisor/lead person. All questions must be answered.

3. Submit a complete and signed copy of the Report to the Office of Workers' Compensation within 24 hours of the injury/illness (email or fax, 410-313-7349). If this is a serious injury/illness (either 911 or an off work status is involved), call the Workers' Compensation Specialist to provide details before sending the form. Keep a copy for your file.

3. The Workers' Compensation First Report of Injury must be completed for all injuries that require medical attention and/or lost time from work.

a. **The principal/facility manager completes this form. The injured/ill employee does not complete or sign this form.**

1. The principal or facility manager must sign and date.

2. Thorough responses must be provided regarding questions about the injury/illness.

3. Submit a complete and signed copy of the Report to the Office of Workers' Compensation within 24 hours of the injury/illness (email or fax, 410-313-7349). If this is a serious injury/illness (either 911 or an off work status is involved), call the Workers' Compensation Specialist to provide details before sending the form. Keep a copy for your file.

4. SISCO is the Workers' Compensation Third Party Claims Administrator for the Howard County Public School System.

a. SISCO will investigate and determine if the claim meets the criteria under Maryland state law for a compensable Workers' Compensation claim.

5. The injured/ill **employee** must **immediately notify** his/her Principal / Supervisor / Lead person if he/she is placed off from work or needs to modify his/her job tasks.

a. Following every appointment (or at the beginning of the next scheduled workday), the employee must submit a copy of their work status to his/her Principal / Supervisor / Lead Person for review of the work status and restrictions

b. Work status reports will be reviewed and job tasks modified as per the work restrictions. Work status reports are required by the Workers' Compensation claim administrator (SISCO), the Workers' Compensation Specialist, and by the employee's school/department for modified duty assignments.

c. The Workers' Compensation Specialist is to be notified by the Principal / Facility Manager / Lead Person when they are unable to modify an employee's job tasks at the employee's regular work site. The Workers' Compensation Specialist will assign the employee to a modified duty position based upon the employee's restrictions, skills, and length of disability.

d. All employees of HCPSS are subject to modified duty assignments. Modified duty assignments are temporary short-term work assignments. Assignments are contingent upon medical status and needs of the school system.

e. Employees are required to provide information concerning work status and medical treatment as requested by the Workers' Compensation Specialist.

f. When an employee returns to work from a leave of absence, he/she must provide the supervisor and Workers' Compensation Specialist medical certification which clearly outlines their workability. The statement must include the date of return to work and any work restrictions, i.e., modified duty. **Note: The doctor must list those things the employee can and cannot do – "modified duty" is not enough.**

g. An employee receiving treatment must schedule appointments before or after work hours, or as close to that time as possible.

6. **All time lost from work due to a work-related compensable injury/illness must be substantiated by the work status report**. During the period of disability, salary compensation will be as follows:

a. No salary will be paid to the employee under Workers' Compensation until SISCO has determined that the claim is compensable.

b. A disability slip is required by the Workers' Compensation Specialist, and by the employee's school/department for payment of lost time from work.

c. Any compensation for lost time due to a work-related injury must be supported by an off-duty status by Concentra Medical Centers or other health clinic. In lieu of any required disability certification, time lost from work will be charged to accrued leave, or if none, leave without pay. Compensable lost time will be paid at the rate equal to or greater than specified by Maryland Workers' Compensation law.

d. Failure to substantiate time away from work by proper medical certification may result in the forfeiture of benefits for full pay under the HCPSS 90-day benefit. It is not a denial of a Workers' Compensation claim or any compensation due under the Workers' Compensation law.

**NOTE:** Employees covered by negotiated agreements, meet and confer agreements and Administrative Management are eligible for salary benefits under the 90-day benefit. Temporary and non-benefited employees are not eligible for this benefit.

7. If the employee is unable to return to work due to a compensable work related injury/illness, HCPSS will pay eligible employees full salary for a period not to exceed 90 workdays without loss of annual, sick, or personal leave or fringe benefits for the employee. The availability of the 90 days expires one year from the date of the injury/illness.

    a. Subject to employee eligibility, a period of incapacity of more than three days will be considered a serious health condition, as defined by the Family and Medical Leave Act (FMLA). Days will be counted under an employee's annual FMLA entitlement (12 weeks/60 working days) and will run concurrently with a Workers' Compensation leave.

    b. During the 90-day period, an employee will be paid at the rate of pay the employee is earning at the time leave is taken.

    c. Employees will be paid for lost wages if time away from work is for an independent medical examination at the request of SISCO or HCPSS.

    d. Failure to use provided safety equipment or improper use of equipment and materials may result in loss of eligibility for full salary benefits under the 90-day benefit.

    e. A claim resulting from an employee's willful misconduct will be subject to denial under the Maryland Workers' Compensation law.

8. After the 90-day period expires and the employee has not returned to work, the employee has the option to use available accrued leave to make up the difference between Workers' Compensation benefits and his/her full regular salary in order to continue to receive full salary payments. If the employee elects not to use accrued leave, or if none is available, the employee will remain on an approved leave of absence without pay and will continue to receive any Workers' Compensation benefits to which he/she is entitled.

a. Any salary payments made by SISCO to the employee, not applicable to the 90-day period, will belong to the employee.

b. Subject to FMLA eligibility, an employee may return to the same or substantially equivalent position and location within 12 weeks (60 working days) of the work related injury/illness. If the employee is not able to return to work within the 12-week time (FMLA) period (including the 90-day period), the employee will be assigned to a same or equivalent position when a vacancy becomes available for which the employee is qualified. The employee will be placed at the grade and step held at the time of injury, or if placed in an equivalent position an appropriate grade and step for that position. Pay increments occurring during an employee's time away from work are subject to approval by the Human Resources Office.

c. After an absence of six months (including the 90-day period), the employee's continued leave and reasonable accommodations will be evaluated on a periodic basis. During this time, the employee may use any available accrued leave.

d. The approved leave of absence will not affect any benefits that may be due under the Workers' Compensation law.

9. The Department of Human Resources will be notified when the 90-day period expires or o f other circumstances which may require consideration for the continued leave of absence.

10. If SISCO has determined that the injury/illness is a non-compensable claim, then:

    a. If the employee is not able to return to work, he/she may use accrued leave, if available, and apply for a leave of absence for the duration of the recovery period. Leave is subject to FMLA.

    b. If leave is not available, the employee must apply for an unpaid leave of absence for the duration of the recovery period. Leave is subject to FMLA.

    c. Reassignment will be determined by the Department of Human Resources.

    d. All time lost from work will be charged to the employee's accrued leave, and if none, the employee will be placed in a no-pay status.

    e. SISCO will notify the employee when a claim has been denied, and will inform the employee of their options of filing an appeal, if desired.

11. If the employee is physically injured in the scope of his/her employment as the result of an assault and is absent due to physical disability that results from the assault, the employee will be kept on full pay status instead of sick leave during the period of

absence. In this case, the following will apply:

a. Assault is defined as a willful, unprovoked attack intended to do harm to another that results in a physical disability.
b. The employee must immediately notify their supervisor of the incident and injury.
c. The employee is required to complete the Employee Incident Report of Injury/Illness and completely describe the incident and why it is considered an assault.
d. HCPSS will file a Workers' Compensation 1st Report of Injury reporting the incident and injury.
e. Procedures for the 90-day full salary benefit are followed, to include certification from the medical provider of the employee's disability.
f. If the employee's disability extends beyond the 90-day full salary benefit, then assault leave may apply. Assault leave is paid leave provided in accordance with §6-111 of the Education Article of Maryland Statute.
g. The employee will submit medical documentation from a licensed physician to SISCO for determination of any Workers' Compensation temporary total benefits that may be due.
h. If SISCO determines that temporary total benefits are due, then the employee will receive Assault leave in lieu of temporary total benefits with no sick leave charged.
i. FMLA will run concurrent with Assault Leave.
j. HCPSS may require a medical examination conducted by a physician selected and paid for by HCPSS.
k. Only permanent employees are eligible for Assault Leave.
l. Assault leave will end when the employee returns to work, temporary total benefits end, and/or if the employee retires.
m. HCPSS may require the employee apply for disability retirement.

Contact the Office of Workers' Compensation at 410-313-7494 with any questions.

## PROCEDURES FOR MEDICAL ATTENTION

## WORKERS' COMPENSATION

### EMERGENCY INJURY/ILLNESS

An employee sustaining a work-related injury/illness that requires emergency assistance (911 or use of an ambulance) shall:

- Call 911 immediately for life-threatening injury/illness.
- Contact next of kin, spouse, or emergency contact person.
- Report all 911 calls to the Office of Workers' Compensation (410-313-7494).
- Unless admitted to the hospital, the employee must report to an Urgent Care (i.e.: Concentra Medical Centers) or other medical clinic on the next business day for work evaluation and/or treatment.
- Follow procedures under Non-Emergency Injury/Illness after visit.

### NON-EMERGENCY INJURY/ILLNESS

An employee sustaining a work-related injury/illness that does not require emergency medical care (911) shall:

- Obtain an Employer's Authorization for Examination or Treatment from his/her principal/supervisor/lead person.
- Employee must report for work evaluation and/or treatment at an Urgent Care location (i.e.: Concentra Medical Center) or other medical clinic.
- Each employee will receive an Activity Status Report or work status slip following their evaluation. Employee shall return either to the principal or designated staff, supervisor, or lead person for a review of the work status and accommodations based on any work restrictions
- Notify the Office of Workers' Compensation if unable to modify the job tasks at the employee's regular work site, or if the employee is placed in an off work status.
- The Office of Workers' Compensation will assign the employee to a modified duty position based upon the employee's restrictions, skills, and length of disability.
- All employees may be assigned to modified duty assignments.

**The Activity Status Report from Concentra Medical Center (or note from any other Urgent Care or medical clinic) must substantiate time away from work due to a work-related injury/illness. A doctor's note is given to the employee at the conclusion of each visit to Concentra Medical Center (or the Employee is obligated to ask for a work status note following an evaluation at an Urgent Care or medical clinic). This note must be given to the employee's principal/supervisor/lead person for review of the work status and restrictions upon return from the evaluation, for review of any necessary job modifications to accommodate work restrictions.**

**Concentra Locations in and near Howard County**

6656 Dobbin Road
Columbia, MD 21045
410-381-1330  Fax 410-381-5585

7377 Washington Blvd.
Jessup, MD 21075
410-379-3051  Fax 410-379-3074

Both locations are open 8:00 am – 5:00 pm Monday through Friday.

# Work-Related Injury/Illness Reporting Checklist

- Unless the injury is serious, please complete the following prior to sending employees for treatment, and forward to the Office of Workers' Compensation **within 24 hours of injury or notification of injury**:

  - **Workers' Compensation – First Report of Injury or Illness**: Supervisor / Principal / Lead Person completes. Please provide as much detail as possible regarding the incident/injury (i.e.: time of occurrence, type of injury/illness, specific activity employee was engaged in and exactly how the injury/illness occurred)

  - **Employee Incident/Injury Report**: injured worker completes Section I; Supervisor / Principal / Lead Person completes Section II. Please ensure the cause of the accident and corrective action in response to the incident/injury are both identified

- You may encourage employees to seek treatment at Concentra Medical Centers (which specializes in work-related injuries); however employees have the option to treat at the medical facility of their choice

- Employees are responsible for providing a copy of their work status to the Supervisor / Facilities Manager immediately after their appointment. A doctor's note must be provided following each doctor visit in order to remain updated on any changes in work status

- If an employee is taken off work, or the temporary work restrictions cannot be accommodated, contact the Office of Workers' Compensation immediately to discuss temporary modified duty or alternative accommodations

- All employees who have been off work due to a work-related injury must submit written authorization to return to work from their doctor ***prior to or upon*** returning to work. The release must indicate the effective date of their return and outline any restrictions which could now be accommodated, or they have been released to regular duty

# WORKERS COMPENSATION – FIRST REPORT OF INJURY OR ILLNESS

## GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)

Howard County Public School System
10910 Clarksville Pike
Ellicott City, MD 21042

SIC CODE

EMPLOYER FEIN: 52-60000968

CARRIER/ADMINISTRATOR CLAIM NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

PHONE #: (410) 313-6600

## CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO)

Self-Insured

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☒ SELF INSURANCE

CLAIMS ADMINISTRATION (NAME, ADDRESS & PHONE NO)

SISCO
RCM&D Self-Insured Services, Co, Inc.
555 Fairmount Avenue
Baltimore, MD 21286-5497
(410) 339-7263

CARRIER FEIN

POLICY/SELF-INSURED NUMBER: 1508

ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

## EMPLOYEE

NAME (LAST, FIRST, MIDDLE)

DATE OF BIRTH

SOCIAL SECURITY NUMBER

DATE HIRED

STATE OF HIRE

ADDRESS (INCL ZIP)

SEX

☐ M MALE
☐ F FEMALE
☐ U UNKNOWN

MARITAL STATUS

☐ U UNMARRIED (SINGLE/DIVORCED)
☐ M MARRIED
☐ S SEPARATE
☐ K UNKNOWN

OCCUPATION/JOB TITLE

EMPLOYMENT STATUS

NCCI CLASS CODE

TELEPHONE (INCLUDE AREA CODE)

# OF DEPENDENTS

## WAGE

RATE

PER: DAY MONTH WEEK OTHER:

# DAYS WORKED/WEEK

FULL PAY FOR DAY OF INJURY? YES NO

DID SALARY CONTINUE? YES NO

## OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM

DATE OF INJURY/ILLNESS

TIME OF OCCURRENCE ☐ AM ☐ PM

LAST WORK DATE

DATE EMPLOYER NOTIFIED

DATE DISABILITY BEGAN

CONTACT NAME/PHONE NUMBER

TYPE OF INJURY/ILLNESS

PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☐ YES ☐ NO

TYPE OF INJURY/ILLNESS CODE

PART OF BODY AFFECTED CODE

DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

ALL EQUIPMENT, MATERIALS OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED

SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED

HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL

CAUSE OF INJURY CODE

DATE RETURN(ED) TO WORK

IF FATAL, GIVE DATE OF DEATH

WERE SAFEGAURDS OR SAFETY EQUIPMENT PROVIDED? ☐ YES ☐ NO

WERE THEY USED? ☐ YES ☐ NO

## TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)

HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT

☐ 0 NO MEDICAL TREATMENT
☐ 1 MINOR: BY EMPLOYER
☐ 2 MINOR: CLINIC/HOSP
☐ 3 EMERGENCY CARE
☐ 4 HOSPITALIZED – 24 HOURS
☐ 5 FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED

## OTHER

WITNESS (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED

DATE PREPARED

PREPARER'S NAME & TITLE (Princ/Supvr's Signature)

PHONE NUMBER

Exhibit A

**Workers' Compensation Office**
**Justin_Waters@hcpss.org 410-313-7494**
**Fax 410-313-7349**

# EMPLOYEE INCIDENT/INJURY REPORT

## SECTION I: Completed by the injured employee (*prior to seeking medical treatment*)

- Please provide responses to all questions in Section I
- Ask your Supervisor/Principal/Lead Person for assistance if you do not understand any questions
- After completing, return the form to your Supervisor/Principal

Employee Name: _____ Employee Number: E_____

Job Title: _____ Home/Cell Phone: _____

School/Facility: _____

Incident Date: _____/_____/_____ Incident Time: _____ ❍ AM ❍ PM

Incident location (hallway, classroom, etc.): _____

Describe in detail what happened. _____
_____
_____
_____

Names of person(s) who witnessed the incident: _____
_____

When did you report the incident? _____ Who did you report it to? _____

Do you require medical treatment? ❍ Yes ❍ No

If "Yes", which medical clinic? ❍ Concentra ❍ Howard County General Hospital ❍ Other

If "Other", please provide name, address and phone number of treatment location: _____
_____
_____

Injured Part of Body and Type of Injury? (i.e. right ankle sprain) _____
_____

**Please provide a copy of your work status immediately following any treatment for a work-related injury, so your Supervisor can be notified of any changes in your workability.**

Signature of Employee _____ Date _____

## Section II: Completed and signed by the Supervisor and/or Principal

- Please provide responses to all questions in Section II; keep a copy for your records
- Scan/email the completed form & First Report of Injury form to Justin Waters ***within 24 hours*** of the injury/illness; serious injuries/911 calls must be reported immediately
- Send original copies in the pony

Who informed you of the incident? _____
How were you informed? _____ When? _____
List any additional information that you may have concerning how the injury occurred.
_____
_____

Please indicate accident cause(s) which contributed to this incident:

❍ **Housekeeping** – unsafe storage, clutter, items on floor, congested work area, untidy work area
❍ **Physical safeguards** – unguarded machinery, warning signs not posted, inadequate protective equipment, defective equipment
❍ **Task methods** – disregard of instructions, operating without authority, unsafe loading/unloading, unsafe posture/position, poor lighting, unsafe methods/procedures/processes, poor ventilation, safeguards not provided, protective equipment not provided, use of equipment/materials unsafely
❍ **Supervision** – inadequate direct supervision, failure to enforce rules, toleration of unsafe practices, protective equipment not used
❍ **Other** – combative student, horseplay, substance use, improper clothing, improper footwear, weather

Please list the steps which will be taken as a result of this incident? _____
_____
_____

Could use of protective equipment (scrub boots, eyewear, etc) prevent this injury? ❍ Yes ❍ No

If this was the result of an auto accident, provide name, address, and insurance information driver/owner: _____
_____
_____

**If this was the result of a human bite/scratch, refer employee to health assistant/cluster nurse for notification requirements.**

Has employee returned to work? ❍ Yes ❍ No If yes, when? _____

Will there be any lost time from work? ❍ Yes ❍ No If yes, start date? _____

If there are any temporary work restrictions, are you able to accommodate? ❍ Yes ❍ No

**If no, contact the Workers' Compensation Office immediately for job placement of the injured employee.**

Signature of Supervisor _____ Date _____

Signature of Principal/Facility Manager _____ Date _____

Concentra™

*(Patient Must Present Photo ID at Time of Service)*

# Authorization for Examination or Treatment

Patient Name: _____ Social Security Number: _____

Employer: _____ Date of Birth: _____

Street Address: _____ Location Number: _____

Temporary Staffing Agency: _____

**Work Related**

❑ Injury ❑ Illness

Date of Injury _____

**Substance Abuse Testing*** (check all that apply)

❑ Regulated drug screen ❑ Breath alcohol

❑ Collection only ❑ Hair collect

❑ Non-regulated drug screen ❑ Rapid drug screen

❑ Other _____

**Type of Substance Abuse Testing**

❑ Preplacement ❑ Reasonable cause

❑ Post-accident ❑ Random

❑ Follow-up

**Physical Examination**

❑ Preplacement ❑ Baseline ❑ Annual ❑ Exit

**DOT Physical Examination**

❑ Preplacement ❑ Recertification

**Special Examination**

❑ Asbestos ❑ Respirator ❑ Audiogram

❑ Human Performance Evaluation*

❑ HAZMAT ❑ Medical Surveillance

❑ Other _____

**Billing** (check if applicable)

❑ Employee to pay charges

Special instructions/comments: _____

_____

_____

_____

★ Due to the nature of these specific services, only the patient and staff are allowed in the testing/treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

Authorized by: _____ Title: _____

Please print

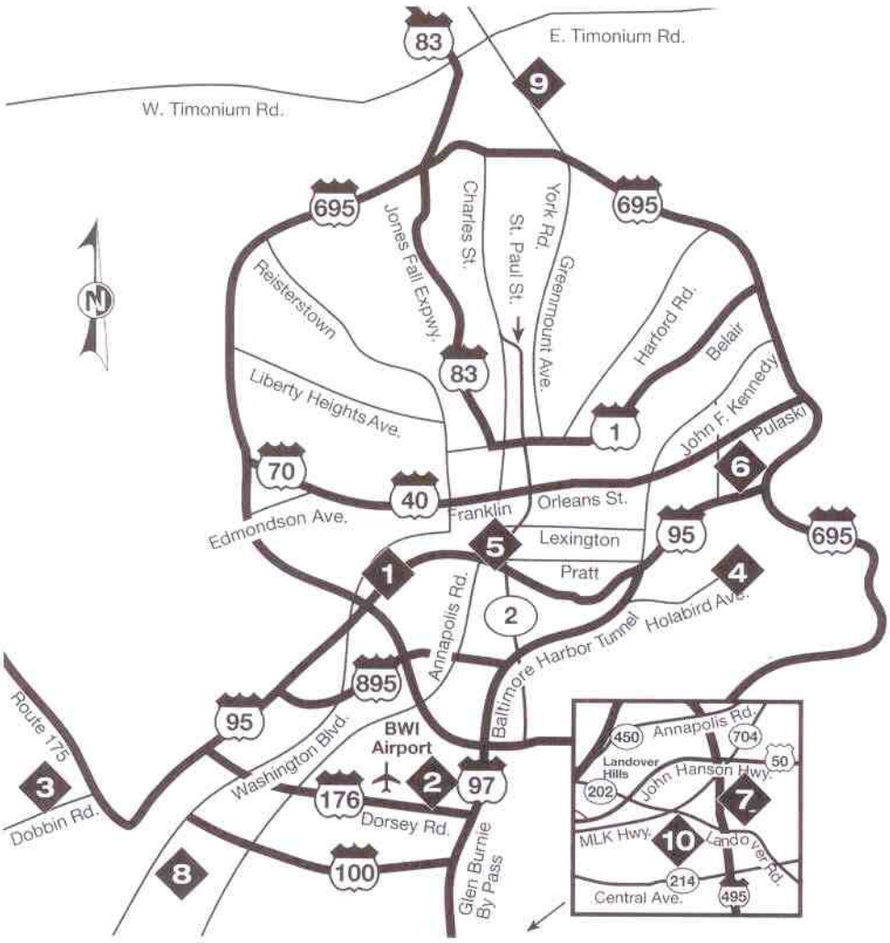
Phone: (_____) _____ _____

Date

Concentra now offers urgent care services for non-work related illness and injury. We accept many insurance plans.

***(Copies of this form are available at www.concentra.com)***

C2119AUTH




**1** Arbutus
AFTER HOURS FACILITY
1419 Knecht Ave.
Baltimore, MD 21227
Mon: 7 am - Sat: 12 pm
410.247.9595
FAX: 410.247.7553

**2** BWI Airport
811 Cromwell Park Dr.
Suite 104-105
Glen Burnie, MD 21061
Mon - Fri: 7:30 am - 5 pm
410.553.0110
FAX: 410.553.0197

**3** Columbia
6656 Dobbin Rd.
Columbia, MD 21045
Mon - Fri: 8 am - 5 pm
410.381.1330
FAX: 410.381.5585

**4** Dundalk
Holabird Business Park
1833 Portal St.
Baltimore, MD 21224
Mon - Fri: 8 am - 5 pm
410.633.3600
FAX: 410.633.3604

**5** Downtown
100 S. Charles St., Ste. 150
Baltimore, MD 21201
Mon - Fri: 8 am - 5 pm
410.752.3010
FAX: 410.539.7023

**6** Rosedale
8101 Pulaski Hwy., Ste. H
Baltimore, MD 21237
Mon - Fri: 7 am - 7 pm
Sat: 7 am - 12 pm
410.687.6462
FAX: 410.687.2261

**7** Lanham
4451 G Parliament Pl.
Lanham, MD 20706
Mon - Fri: 7 am - 8 pm
Sat: 7 am - 12 pm
301.459.9113
FAX: 301.459.1214

**8** Jessup
7377 Washington Blvd.
Suite 101
Elkridge, MD 21075
Mon - Fri: 8 am - 5 pm
410.379.3051
FAX: 410.379.3074

**9** Timonium
Yorkridge Center
1840 York Rd., Ste. E
Timonium, MD 21093
Mon - Fri: 8 am - 5 pm
410.252.4015
FAX: 410.252.7410

**10** Landover
8700 Central Ave.
Landover, MD 20785
Mon - Fri: 8 am - 5 pm
301.499.4655
FAX: 301.499.0902

C2110AUTH

Howard County PUBLIC SCHOOL SYSTEM

**The Howard County Public School System (HCPSS) will evaluate each employee's return to work situation so that he/she may return to work as safely and quickly as possible. Please provide responses to each applicable section below and fax to 410-313-7349, or scan to Justin_Waters@hcpss.org. HCPSS will review the information provided below and determine available temporary accommodations and/or modified duty opportunities during the recovery period.**

**Patient Name:** **Date of Injury/Onset:**

Diagnosis / Condition: _____

Status: ☐ First visit ☐ Improved ☐ Unchanged ☐ Symptoms Worse ☐ Discharged

## I examined the patient/employee on _____and recommend one of the following sections:

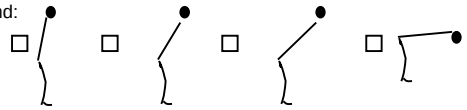
## I. ❍ EMPLOYEE MAY RETURN TO REGULAR DUTY WORK.

## II. ❍ EMPLOYEE MAY RETURN TO WORK WITH THE FOLLOWING RESTRICTIONS:

**Items not marked indicate no restriction. Please note any additional comments at bottom.**

**(Frequency definitions: Never = 0 hours/day; Seldom: 1-2 hours/day; Occasionally: 2-5 hours/day; Frequently; 5-8+ hours/day)**

### RANGE OF MOTION

May bend: ☐  ☐ ☐ ☐

| | | | | |
|---|---|---|---|---|
| Bend: | ☐ Never | ☐Seldom | ☐Occas. | ☐Freq. |
| Squat: | ☐ Never | ☐Seldom | ☐Occas. | ☐Freq. |
| Climb: | ☐ Never | ☐Seldom | ☐Occas. | ☐Freq. |
| Crawl: | ☐Never | ☐Seldom | ☐Occas. | ☐Freq. |
| Twist: | ☐ Never | ☐Seldom | ☐Occas. | ☐Freq. |
| Kneel: | ☐ Never | ☐Seldom | ☐Occas. | ☐Freq. |

### HAND RESTRICTIONS

| | *Specify | ☐ Left | ☐ Right | ☐ Both | |
|---|---|---|---|---|---|
| Grasp/Pinch: | | ☐Never | ☐Seldom | ☐Occas. | ☐Freq. |
| Twist (wrist): | | ☐Never | ☐Seldom | ☐Occas. | ☐Freq. |
| Push/Pull with hand(s): | | ☐Never | ☐Seldom | ☐Occas. | ☐Freq. |
| Finger manipulation: | | ☐Never | ☐Seldom | ☐Occas. | ☐Freq. |
| Wrist flexion/extension: | | ☐Never | ☐Seldom | ☐Occas. | ☐Freq. |

### REACHING

| | *Specify | ☐ Left | ☐ Right | ☐ Both |
|---|---|---|---|---|
| Frequency; | | ☐5X / min. | ☐10X / min. | ☐15X / min. |
| Distance; | | ☐12 inches | ☐18 inches | ☐24 inches |

### LIFTING/PUSHING/PULLING (Pounds)

| Maximum Weight: | Frequency: | | | |
|---|---|---|---|---|
| ____ | Floor to Waist: | ☐ Never | ☐Seldom | ☐Occas. ☐Freq. |
| ____ | Waist to Shoulders: | ☐ Never | ☐Seldom | ☐Occas. ☐Freq. |
| ____ | Shoulders & Above: | ☐ Never | ☐Seldom | ☐Occas. ☐Freq. |

### CARRYING

| Maximum Weight: | Frequency: | | | |
|---|---|---|---|---|
| ____ | Floor to Waist: | ☐ Never | ☐Seldom | ☐Occas. ☐Freq. |
| ____ | Waist to Shoulders: | ☐ Never | ☐Seldom | ☐Occas. ☐Freq. |
| ____ | Shoulders & Above: | ☐ Never | ☐Seldom | ☐Occas. ☐Freq. |

### GENERAL WORK ACTIVITIES

May drive _____ hours at a time
May sit _____ hours at a time
May walk _____ hours at a time
May stand _____ hours at a time
Should change positions every _____ hour(s)

**Duration of restrictions** _____ through _____. Will be re-evaluated on _____.
Do the above noted restrictions apply to off-the-job activities? _____Yes _____No
If no, please explain _____
Employee is able to work _____ hours per day

## III. ❍ EMPLOYEE MAY NOT RETURN TO WORK AT THIS TIME: Will be re-evaluated on _____.

***Please explain why employee may not return to work in "comments" section below.**

Comments:

_____

_____

_____

**Treating Facility** _____ **Phone** _____

**Physician's Name (please print)** _____**Signature**_____