



Modified Work Policy

PURPOSE

Modified work assists in the rehabilitation and early return to work of ill or injured employees.

1.0 POLICY

- 1.1 Vulcan County will make every reasonable effort to provide suitable (temporary) modified employment to any employee unable to perform their regular duties. This may include a modification of the employee's original position, providing alternate duties, providing transitional work, or providing a training opportunity.
- 1.2 Only suitable work that is in accordance with the Worker's Compensation Board (WCB) Temporary Modified Work Programs policy shall be considered for use in the Modified Work Program.
- 1.3 Participants placed on modified work will be expected to provide feedback in order to improve the program.
- 1.4 All employees, regardless of injury or illness, will be considered for placement in the Modified Work Program.
- 1.5 In the event that the Modified Work Program will require the employee to work alone, the employee shall work in accordance with the Vulcan County Working Alone Policy.
- 1.6 Any employee engaged in the Modified Work Program, and performing duties not within their normal job description and as approved by their manager, will be covered by the Vulcan County insurance carrier.

SCHEDULE "A"

MODIFIED WORK POLICY

MEDICAL RELEASE FORM

(Date)

To Whom It May Concern:

I, _____, hereby authorize the release of my medical information, only insofar as it pertains to my fitness for work, to my employer, Vulcan County, for the purpose of co-coordinating my return to work in my pre-injury duties or under the Vulcan County Modified Work Program.

Signature

Witness

Signed on this _____ day of _____, 20_____.

This information is being collected under the authority of the Municipal Government Act and will be used for the direction, control and management of Vulcan County's Chief Administrative Officer. The privacy provisions of the Freedom of Information and Protection of Privacy Act protect it. If you have any questions, contact the FOIP Coordinator at 403-485-2241.

SCHEDULE "B"

**MODIFIED WORK POLICY
MEDICAL ASSESSMENT FORM**

Employee Name: _____

Job Classification: _____

Injury Sustained: _____

Is the Employee fit for regular duty? Yes No

If not, can the employee perform modified or alternate duties? Yes No

Current work capability (as per WCB Physician's Report Form):

- Sedentary
- Light
- Medium
- Heavy
- Very Heavy

Are there any further specific physical restrictions or recommendations?

Expected length of modified duty: _____

The Employee will be unable to work from _____ to _____.

Next medical review: _____

Additional Comments:

Attending Physician

Date

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