

# YOUTH SERVICES POLICY

<b>Title:</b> Return to Work	<b>Type:</b> A. Administrative <b>Sub Type:</b> 2. Personnel <b>Number:</b> A.2.28
	<b>Page 1 of 7</b>
<b>References:</b> La. R.S. 39:1547; YS Policy Nos. A.1.19 "Ebola Virus Disease", A.2.1 "Employee Manual"; A.2.5 "Family and Medical Leave of Absence", A.2.13 "Americans with Disabilities Act - (Employees, Applicants, Candidates, Visitors)", A.2.47 "Equal Employment Opportunity"; and A.2.49 "Worker's Compensation"; Division of Administration Office of Risk Management's INSURANCE INFORMATION NOTICE 2015-1 "Transitional Duty Return to Work Plan"	
<b>STATUS: Approved</b>	
<b>Approved By:</b> <i>William A. Sommers, Deputy Secretary</i>	<b>Date of Approval:</b> 08/16/2022

**I. AUTHORITY:**

Deputy Secretary of Youth Services (YS) as contained in La. R.S. 36:405. Deviation from this policy must be approved by the Deputy Secretary.

**II. PURPOSE:**

To establish policy relative to an employee's return to work following an injury or illness and to provide safe return to work options.

**III. APPLICABILITY:**

All YS employees.

It is the Unit Head's responsibility to ensure that necessary procedures are in place for the proper management and administration of this policy.

The Deputy Undersecretary shall serve as the Americans with Disabilities Act (ADA) Coordinator for Youth Services. (Refer to YS Policy No. A.2.13)

**IV. DEFINITIONS:**

***Essential Functions Form (EFF)*** - A form generated by YS' Human Resources (HR) Liaisons that lists the fundamental job duties of a position.

***First ADAAA Questionnaire (Americans with Disabilities Act Amendments Act)*** - A standard form to be completed by an employee's treating healthcare provider(s) when accommodations are requested [see Attachment A.2.28 (b)].

**Lost Time** - The period of time that an employee is absent from work due to a work related injury or illness.

**Medical Certification Form** - A standard form to be filled out by an employee's treating physician [see Attachment A.2.28 (a)].

**Office of Risk Management's (ORM's) Third Party Administrator (TPA)** – SEDGWICK Management Services, Inc.

**Return to Work (RTW) Board** - A board made up of at least three (3) members assigned to review RTW cases. Typically, the RTW Board shall consist of the unit's Safety Officer, the returning employee's immediate supervisor or a supervisor in the returning employee's chain of command, and the unit's HR Liaison.

**Return to Work Coordinator** – The Unit's Human Resources (HR) liaison or the employee's immediate supervisor at each OJJ site.

**Transitional Duty** - A work assignment that is not necessarily the same position or assignment that an employee had before the employee went out on sick leave for an illness or injury. Transitional duty may include various accommodation types such as modified and alternate work. Modified work includes modifications to the job tasks, functions, hours of work, frequency of breaks, worksite, or any combination of these. Alternate work is different from an employee's pre-injury job or illness and offered to a worker who is temporarily or permanently unable to perform their pre-injury work. A transitional duty assignment shall not displace others from their jobs.

**Transitional Return to Work (RTW) Board** – The Board assigned to review work-related RTW illness/injury. Typically, the Transitional Return to Work Board shall consist of the unit's Safety Officer, the returning employee's chain of command, the unit's HR Liaison, a management representative, ORM Third Party Administrator, and the ORM Third Party Administrator Vocational Rehabilitation Counselor as needed.

**Training Records Entry Completed (TREC)** – The database used to track training hours of YS employees at some secure facilities.

**Unit Head** – For this policy, the Deputy Secretary, Facility Directors and Regional Managers.

**YS Central Office** - Offices of the Deputy Secretary, Assistant Secretary, Undersecretary, Deputy Undersecretary, Chief of Operations, Probation and Parole Program Director, Youth Facilities Director – Statewide, Executive Management Advisor, General Counsel, Regional Directors, and their support staff.

**V. POLICY:**

It is the Deputy Secretary's policy to accommodate employees who sustain injuries or illnesses, and who are temporarily unable to perform the duties of their assignment, but who can, with medical clearance, return to work to perform most of the duties of their assignment or the duties of another assignment. These employees will be accommodated by temporary placement in a transitional duty assignment whenever possible. Such temporary transitional duty assignments shall be meaningful and productive within the safe parameters of the injured employee's capabilities, and not displace other employees from their job. This applies only to a temporary inability to perform all essential functions of the position, and not to a permanent inability to perform such functions.

YS' transitional return-to-work plan shall be based on medical prognosis and recovery, and shall be compatible with the agency's business necessity.

**VI. GENERAL:**

An employee who is absent from work for a period of time due to injury or illness may be required to provide an up-to-date "Essential Functions Form" (EFF) and a "Medical Certification Form" [see Attachment A.2.28 (a)] when they believe that they are ready to return to work. Re-certification may be required periodically thereafter as determined by the Unit Head on a case-by-case basis. A "Physician's Modified Work Information Sheet" may also be accepted at the Unit Head's discretion instead of the "Medical Certification Form".

The "First ADA/AA Medical Questionnaire" [see Attachment A.2.28 (b)] completed by all treating healthcare providers may also be required when the employee is requesting accommodations to perform the essential functions of their job. (Attachment A.2.28 (b) shall be drafted by a designated YS attorney when needed.)

**VII. PROCEDURES:**

- A. The employee must contact the Human Resources (HR) Liaison at the unit level, or immediate supervisor at Central Office, and advise that they are ready to return to work.
- B. The unit's HR Liaison (or employee's immediate supervisor at Central Office) shall send the employee the "EFF" and "Medical Certification Form". The "First ADA/AA Medical Questionnaire" may also be required by the employee if the employee is not able to return to full duty or is requesting accommodations. Failure to return any of these forms is a failure to follow a direct written order and may result in disciplinary action, pursuant to YS Policy No. A.2.1 (b).

- C. When the forms are returned to the unit's HR Liaison (or immediate supervisor at Central Office), the HR Liaison or supervisor shall schedule a Return to Work (RTW) Board hearing without delay. The RTW Board shall be assembled, depending upon which potential members can be most readily available, in consultation with the Unit Head as needed. When the makeup of the Board is determined, the unit's HR Liaison shall forward copies of the employee's forms to the Board members.

1. **Non-Work Related Illnesses or Injuries**

- For illnesses or injuries that are not work related, the RTW Board typically will consist of the unit's Safety Officer, the returning employee's immediate supervisor or a supervisor in the returning employee's chain of command, and the unit's HR Liaison. If these named staff persons are unable to attend, a reasonable substitute may be made by the Unit Head. Acceptable persons would be staff from any YS unit serving in the same or like capacities as the person they are substituting. (Examples are as follows: Safety Officer or Risk Management personnel; a direct care supervisor; and the HR Liaison or higher from any unit.) In some cases, a representative from YS Legal Services may attend.

Security or professional staff may also attend the hearing at the request of the Unit Head, or if they have authorization from the Unit Head.

In order for a person to be returned to work, including those on FMLA, there must be unanimous concurrence by the RTW Board Members. If there is no unanimous decision, the hearing shall be recessed for a meeting of the RTW Board and the Unit Head as soon as possible. After such meeting, the Unit Head shall decide whether the employee may return to work or not, and under what conditions or restrictions. The actions of the body/bodies handling the employee's return to work hearing shall be preserved in writing by the unit's HR Liaison. A copy of the actions in writing shall be furnished to the employee. A copy shall also be placed in the employee's official personnel record.

2. **Work Related Illnesses or Injuries**

- For work related illnesses or injuries, the Transitional RTW Board shall review all lost time worker's compensation employees under its authority. The Board shall consist of the unit's HR Liaison, the returning employee's immediate supervisor, unit's safety officer, a management representative, the claim adjuster for the Office of Risk Management's (ORM) Third Party Administrator (TPA), ORM TPA RTW coordinator, and the ORM TPA vocational rehabilitation counselor as needed.

- The ORM TPA RTW Coordinator is the primary contact for employees and outside agencies on matters related to disability management and return to work planning. The ORM TPA RTW Coordinator's responsibilities include, but are not limited to, overall coordination and day to day administration of the disability management plan; development, facilitation, and monitoring of the return to work plan; and development and facilitation of accommodations.
  - The unit's HR Liaison, other staff as designated by the Unit Head, or the immediate supervisor, if located at the Central Office, may also contact the employee to obtain the necessary information related to disability management and return to work planning.
  - The Transitional RTW Board shall meet monthly based on the size of the agency and the number of lost time claims or when an employee is injured and/or there is a change in the injured employee's medical status. Board meetings are not necessary if there are no active lost time claims.
- D. When the RTW Board members are reviewing an employee's eligibility for return-to-work options, they shall review the job task of the employee's pre-injury/illness position, identify transitional tasks that can be performed, review other services or tasks that can be performed which would improve the overall function of YS/OJJ; and review tasks that can be performed that would return an employee to gainful employment.
- E. If the employee's physician certifies that the employee is able to return at the employee's full capacity, the employee may be returned to the position held before the employee was out on leave due to illness or injury. If the employee's physician certifies the employee's current condition prevents the employee from returning to the regular full duty position, the employee may be eligible to be placed in a transitional duty assignment. An offer of a transitional duty assignment shall be in writing. If the employee is represented by counsel, the notice shall be sent to the employee via counsel.
- F. A transitional duty assignment may initially last for six (6) months. Requests by the appointing authority to the Director of State Civil Service may be made for an additional six (6) month period (up to one (1) year total) or until the employee can medically return to full duty, whichever comes first. If the employee is not fully recovered after this time, the employee shall return to Workers' Compensation (refer to YS Policy No. A.2.49) or sick leave status, and shall no longer be eligible for transitional duty.

Although every effort shall be made to return an employee to duty as early as medically possible, YS does not guarantee alternative placement or the availability of a modified duty assignment.

- G. When an employee returns to work on a transitional duty assignment, the employee shall not be required to perform tasks that have not been approved by the treating physician. The plan must be evaluated every 30 days to assess the employee's ability to return to full duty. The ORM's TPA is responsible for communications with medical personnel when the illness or injury is work related. YS shall not have direct contact with the treating medical personnel without the approval of the ORM's TPA.
- H. Employees who refuse to cooperate with YS and the ORM may lose benefits.
- I. When the injury or illness is work related, the unit's HR liaison (or immediate supervisor at Central Office) must notify the ORM's TPA if an employee is at risk of termination due to exhaustion of sick leave. Termination of employment because an injured worker has exhausted sick leave is not an alternative to transitional return to work. The unit's HR liaison (or immediate supervisor at Central Office) should:
- Maintain documentation of failed transitional return to work employment;
  - Maintain documentation of efforts made to identify transitional return to work tasks;
  - Maintain documentation of barriers in identifying transitional return to work;
  - Document the necessity to terminate employment, which shall include evidence that transitional return to work tasks could not be identified; and
  - Notify the RTW Coordinator for ORM's TPA when an injured worker is removed from work or the accommodations are no longer available.

**VIII. MEASURE OF EFFECTIVENESS:**

The attached "Transitional Duty Employment Audit Form" (DA WC4000) shall be utilized by the unit's HR liaison (or ADA Coordinator for Central Office) to measure the effectiveness of YS' transitional duty employment program. The form shall be filled out on a monthly basis by office/facility administrative or human resources staff and kept on file at the office or facility. A copy of the form shall be provided to the unit safety officer on a monthly basis.

This information shall be tracked as long as the employee is receiving worker's compensation indemnity benefits.

This report will be reviewed by the Loss Prevention section of ORM's TPA during their annual loss prevention audit of YS.

**IX. STAFF DEVELOPMENT:**

Unit Heads/designees shall ensure that employees are properly trained in Return to Work (RTW).

New hire staff shall be trained within 90 days of hire during pre-service/orientation and every five (5) years thereafter. The training shall be provided electronically, via video recording or in a classroom-type environment, and provided by designated staff assigned to HR or other unit staff knowledgeable of the contents of RTW.

Unit Heads shall also ensure that all training is documented and entered in LEO or TREC by designated unit staff.

**Previous Regulation/Policy Number:** A.2.28

**Previous Effective Date:** 08/08/2019

**Attachments/References:** A.2.28 (a) Medical Certification Form.January2018  
A.2.28 (b) First ADAAA Medical Questionnaire. April 2016  
A.2.28 (c) Confirmation of Receipt.August 2022  
Transitional Duty Employment Audit Form (DA WC 4000) 06/2020  
Transitional RTW Flow Chart

**MEDICAL CERTIFICATION FORM**

Employee Name: \_\_\_\_\_ Unit/Job Title: \_\_\_\_\_

Health Care Provider Name: \_\_\_\_\_ Title: \_\_\_\_\_

Health Care Provider Address and Phone Number: \_\_\_\_\_

**RETURN TO WORK FULL DUTY WITH NO RESTRICTIONS? YES NO DATE:**

Is this Condition: \_\_\_\_\_ Temporary \_\_\_\_\_ Permanent

Date the Condition Began: \_\_\_\_\_ Date Return to Work: \_\_\_\_\_

Does this condition allow the employee to perform the Essential Functions of this job? \_\_\_\_\_ YES \_\_\_\_\_ NO

If not, please describe what **temporary restrictions** are needed for which essential function. Use an additional page if needed.**(Complete this section only if requesting accommodations under the Americans with Disabilities Act.)**

Describe nature of disability, major life functions affected, functional limitations and prognosis.

**The following details the employee's current capabilities for evaluation of MODIFIED WORK ONLY:  
(please check as appropriate)**

	1 to 2 lbs	3 to 5 lbs	6 to 10 lbs	11 to 20 lbs	21 to 30 lbs	31 to 40 lbs	41 + lbs
Lifting							
Carrying							
Push/Pull							

	Minimal	Under 1 Hr	1-2 Hrs	2-3 Hrs	3-4 Hrs	4-5 Hrs	5-6 Hrs	8 Hrs
Sitting								
Standing								
Walking								

	YES	NO
Squatting		
Bend/Twist at Waist		
Reaching		
Work above Shoulder		

Restrictions effective until (date): \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**First ADAAA Medical Questionnaire Pertaining to [Employee's Name]**

(Employee Name) is employed as a (Job Title) with the Department of Public Safety, Office of Juvenile Justice. Attached are his/her Position Description and the Physical Requirements and Conditions of (Employee Name)'s (Job Title) position.

The Office where (Employee Name) works (Insert general description of work performed).

The essential job duties for (Employee Name) serving in the (Job Title) position in the Office of Juvenile Justice include, but are not limited to, the following:  
(Insert specific job duties for the employee requesting an accommodation).

(Employee Name)'s job duties as a (Job Title) are generally performed (Insert specific physical requirements).

The facts which compelled this inquiry are as follows:

During the week of (month/date/year), (Employee Name) advised his/her chain of command that he/she had been diagnosed with (diagnosis). He/she indicated that the condition was affecting his/her ability to do his/her job.

Since (Employee Name) has set forth that he/she has medical conditions for which he/she may be unable to perform an essential function(s) of his/her job and is seeking an accommodation, the employer requires further explanation as to his/her condition and possible accommodations, if necessary and possible, to assist in the performance of his/her duties.

In view of the foregoing, please respond to the following:

1. It is has been set forth that (Employee Name) has (Name/Description of condition if known). Please confirm that (Employee Name) has been diagnosed with and currently has this condition.

Yes       No

Explain Answer:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Does (Employee Name) currently have any other condition(s) that impacts his/her ability to perform his/her job duties? If yes, please identify the condition(s).

Yes       No

Explain Answer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Does this condition(s) affect a major bodily function (e.g. functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and/or reproductive functions)?

(Insert Name of Known Condition) :  Yes       No

Other Condition \_\_\_\_\_:       Yes     No

Explain Answer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Does this condition(s) affect one or more of the body's multiple systems (e.g. special sense organs, neurological, musculoskeletal, respiratory, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin and endocrine systems or a mental or psychological disorder)?

(Insert Name of Known Condition):  Yes  No

Other Condition \_\_\_\_\_:       Yes     No

Explain Answer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Does this condition(s) substantially limit a major life activity (e.g. caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and/or working)?

(Insert Name of Known Condition): \_\_\_ Yes \_\_\_ No

Other Condition \_\_\_\_\_: \_\_\_ Yes \_\_\_ No

Explain Answer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What is the nature of this condition(s)—permanent, temporary, episodic, etc.? Please provide an answer for each condition.

Explain Answer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Does this condition(s) prevent (Employee Name) from performing any of the essential functions of his/her job as detailed above and/or as provided in the attached position description and physical requirements and condition?

(Insert Name of Known Condition): \_\_\_ Yes \_\_\_ No

Other Condition \_\_\_\_\_: \_\_\_ Yes \_\_\_ No

Explain Answer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. If response to 7 above is yes, describe the essential function(s) affected by the condition(s) and how it is affected.

---

---

---

---

---

---

---

---

---

---

---

---

9. Please provide any suggested accommodations, if necessary, which would allow (Employee Name) to perform his/her job duties? Explain answer, including how this accommodation would allow (Employee Name) to perform his/her job duties and lessen the impact of the condition:

---

---

---

---

---

---

---

---

---

---

---

---

10. Can medication or aids mitigate the effects of this condition(s)?

Yes       No

Explain Answer: \_\_\_\_\_

---

---

---

---

---

---

11. Please include any additional, relevant information:

---

---

---

---

---

---

---

---

---

---

---

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Doctor

Phone No: \_\_\_\_\_

\_\_\_\_\_  
Name of Doctor (Print)

\_\_\_\_\_

\_\_\_\_\_  
Type of Practice (Print)

\_\_\_\_\_  
Address of Doctor (Print)



**STATE OF LOUISIANA  
YOUTH SERVICES  
YS Policy No. A.2.28 "Return to Work"**

Employee Confirmation of Receipt

This is to acknowledge that I, \_\_\_\_\_

received training on YS Policy No. A.2.28 "Return to Work" and that the procedures for returning to work following an injury or illness were explained.

I further acknowledge that if I have any questions or need assistance I will seek guidance from my supervisor.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee's Name (printed and legible)

\_\_\_\_\_  
Date

**TRANSITIONAL DUTY EMPLOYMENT AUDIT FORM – DA WC4000**

The purpose of this form is to record an agency's Transitional Duty activity for the **current month** only. It is not cumulative.

Month of Report \_\_\_\_\_ Location code \_\_\_\_\_

Agency \_\_\_\_\_ Contact Person \_\_\_\_\_

**The agency has developed and implemented a Transitional Duty Employment plan: \_\_\_\_\_ Yes \_\_\_\_\_ No**

**Transitional Duty Employment is monitored at the department level:  
\_\_\_\_\_ Yes \_\_\_\_\_ No**

**REPORT THE FOLLOWING ACTIVITY:**

1. Number of lost time workers' compensation claims during the month of reporting: \_\_\_\_\_. \*
2. Number of employees returned to work on transitional duty: \_\_\_\_\_.
3. Number of employees returned to work full duty: \_\_\_\_\_.
4. Number of employees on workers' compensation at month's end: \_\_\_\_\_.
5. The RTW committee has met and reviewed all W/C claims eligible for Transitional Duty Employment: \_\_\_\_ yes \_\_\_\_ no \_\_\_\_ n/a.

**\*NOTE: Lost time refers to whole days an employee has missed from work due to a work-related accident for which indemnity benefits would be paid.**

**Please keep completed forms on file at the location or department level that is responsible for Transitional Duty Employment.**

**THIS FORM IS FOR INTERNAL USE ONLY.**

**FORM DA WC4000  
REVISED 06.2020**

# Transitional Return to Work Flowchart

