

Transitional Work Program - Letter to Attending Physician

Date: _____

RE: Worker Name _____ Date of Birth _____

In conjunction with the Ohio Bureau of Workers' Compensation, our company has developed a Transitional Work Program that supports our employees with health problems in their efforts to return to work or to remain safe and productive at work. "A *transitional work program uses real job duties that accommodate an injured worker's medical restrictions for a specified time period to gradually return the injured worker to their original job.*" - James Conrad, BWC Administrator/CEO.

Workers that participate in our Transitional Work Program may also receive work-site transitional therapy services provided by a physical or occupational therapy professional with our preferred provider, **LTC Consultants (937-623-2733)**. These services may include:

1. Initial and periodic workability injury assessments by a physical or occupational therapist.
2. An ergonomic study of the job in relation to the worker's physical abilities to determine the job's physical demands, identify safe work tasks, and accommodation options.
3. Prescription and progression of suitable exercise and transitional work activities.
4. Instruction in safe work practices (pacing, body mechanics) to reduce the risk of re-injury.

To assist your patient in maintaining employment with our company, please complete the section below and fax it to my attention. Your response may be used as a prescription to initiate services.

TO BE COMPLETED BY ATTENDING PHYSICIAN

My patient may participate in a Transitional Work Program within the following work restrictions that are specified on the attached MEDCO 14.

My patient may participate in Work-Site Transitional Therapy as requested on the BWC C-9 Form. Fax to **LTC Consultants (937-427-3275)**. This program of Work-Site Transitional Therapy includes periodic assessments and progression of work and therapy activities by a physical or occupational therapist.

No, my patient would not benefit from participation in the Transitional Work Program. If No, please explain why you will not allow your patient to participate in our Transitional Work Program (e.g. released to full duty per the attached MEDCO 14; confined to a hospital, bed or home):
Comments _____

Date of next visit _____

Diagnosis _____

Physician's Signature

Print Name

Date