ALBERTA PROFESSIONAL SERVICES, INC.

Early Return to Work Program

Alberta Professional Services, Inc.
3107 South Elm-Eugene St, Building A, Greensboro NC 27406-5201
Phone: 336-273-2640 Fax: 336-273-6522
Albertakids.com

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Policy Statement

Alberta Professional Services, Inc is committed to providing and promoting a safe and healthy workplace for our employees. Preventing accidents, injuries, and illnesses is our primary objective.

When an employee is injured on the job, **Alberta Professional Services, Inc** will use our return-to-work process to assist the employee in returning to work as soon as medically feasible. We will arrange for immediate, appropriate medical attention for employees who are injured on the job. We will attempt to create opportunities for them to return to safe, transitional work assignments as soon as medically possible. The process may have different names (return-to-work program, modified work assignments, transitional duty); however, our goal remains the same: to return injured employees to safe work.

Our ultimate goal is to return our injured employees to their original jobs. If an injured employee is unable to perform all the tasks of the original job, **Alberta Professional Services, Inc** will make every effort to provide a transitional work assignment that meets the injured worker's capabilities.

The success of this process involves the combined efforts of management, employees, our designated medical provider(s), and our workers' compensation insurance carrier (Synergy Coverage Solutions, LLC).

Eric Krohn,
Derek Mitchell,
Tom Duehring
Owners

Responsibilities

Employee's Responsibilities:

- **As an employee, you must first review and follow the procedures for reporting an injury.** If you are injured at work, inform the treating medical provider that transitional work is available to you. If time permits, your supervisor should provide a letter for you to take to your medical provider. This letter will explain the company's return-to-work process.
- If the medical provider restricts you from working, contact the company's designated return-to-work coordinator or your supervisor and provide a copy of the treating physician's release-to-work form that explains any and all work restrictions. Keep the company's return-to-work coordinator and your supervisor informed of your progress and any change in work status.
- If the medical provider indicates you can return to transitional work with restrictions, follow the doctor's orders. Do not exceed the physical restrictions outlined by the treating physician.
- When you are released to regular work, you will need to report to work on the next available shift.

Supervisor's Responsibilities:

- Supervisors are responsible for providing training on the proper way to report work-related injuries, accidents and incidents. You must also discuss the company's return-to-work process with all employees who report to you.
- If possible, accompany the injured worker to the medical provider and inform the physician about your company's commitment to the return-to-work process. Take a return-to-work summary letter with you so the clinic can keep it in the injured worker's medical file.
- Be sure to stay in touch with the injured workers who are placed on a "restricted/no-work status." Contact the injured worker at least once a week to express your concern for his/her well being. Confirm that all necessary forms are completed. Verify with the injured worker that he/she is adhering to the medical restrictions.
- Keep the company's return-to-work coordinator or supervisor informed of the injured worker's medical status.
- Assist all individuals involved in a workplace injury situation. Inform them of appropriate transitional work that will be meaningful to the company and to the injured employee.

Healthcare Provider's Responsibilities:

- Under applicable North Carolina laws/statutes, **Alberta Professional Services, Inc** has chosen a designated medical provider for the treatment of all work-related incidents. Our provider has the following responsibilities:
    - Offer immediate and appropriate medical care to the injured worker.
    - Evaluate the injured worker's ability to work.
    - Communicate with the injured worker's employer regarding the patient's status and ability to return to work.
    - Become familiar with the operations, environment, and return-to-work policies of the injured worker's organization.
    - Explain to the injured worker any appropriate physical restrictions that may be needed if the worker returns to work to perform his/her essential job functions. Explain to the injured worker the restrictions that are being given and why. Make sure the employee understands that these restrictions are for his/her protection.

Workers' Compensation
Medical Provider Authorization & Billing Instructions

Patient Name:	
Employer:	
Injured Body Part:	
Date of Injury:	

Dear Medical Provider,

This letter will verify and authorize initial treatment for the above-mentioned employee's work-related injury. Please be advised that our Workers' Compensation administrator is **Synergy Coverage Solutions, LLC**. Please read the following important instructions:

1. Please initial/sign the **Transitional Duty Task List** and return to Synergy Coverage Solutions; please also return a copy to the Injured Worker to hand to their Supervisor. This will help us in finding modified duty work within their limitations and capabilities you have outlined.
2. Please confirm with the injured worker's Supervisor to determine whether or not a Post-Accident Drug Test is required. If yes, Synergy recommends that at least a 10-panel drug screen is performed to include the following substances:
   - Cocaine
   - Marijuana
   - Opiates
     (codeine, morphine, hydrocodone, hydromorphone)
   - PCP
   - Amphetamines
     (both prescribed and street amphetamines)
   - Benzodiazepines
   - Methadone
   - Oxycodones
     (oxycontin, Percocet)
   - Barbiturates
   - Buprenorphine
3. Submit all charges on CMS 1500 (red form), UB04 form, or accordingly on each state's industrial commission approved form. **Please include the claim number, medical notes and W-9 form.** For expedited processing, please email forms & invoices to: vendoremails@synergyinsurance.net or fax to (704) 927-2867.

   Should you prefer to send invoices & forms by mail, please submit to:
   Synergy Coverage Solutions
   Attn: Claims
   217 South Tryon Street
   Charlotte, NC 28202
   **Please do not send any invoices to the employer or injured worker*
4. Approved Providers: All Synergy claims have the following partners associated:
   - Mitchell
     Medical Network
   - Helios
     Pharmacy Network

If you have any questions please call Synergy Coverage Solutions at (704) 927-2860 or 1-866-710-0908.

Thank you,

X ______________________________
Employer Representative

ALBERTA PROFESSIONAL SERVICES, INC.

Transitional Duty Task List

Evaluating Physician: Please indicate tasks you feel are within the current physical capacities of the employee you are treating. All tasks have been classified as sedentary or sedentary/transitional and can be used to accommodate most types of injuries. Physical capacities of each task are available by fax.

- ☐ Manage incoming calls
- ☐ Make signs & posters
- ☐ Shred designated materials
- ☐ Stuff envelopes
- ☐ Make copies
- ☐ Distribute mail
- ☐ Update bulletin boards, newsletters
- ☐ Routine clerical work
- ☐ Data entry
- ☐ Greet guests & direct to appropriate department or staff member
- ☐ Manage inventory
- ☐ Organizing & filing
- ☐ Parking lot surveillance
- ☐ Pick up trash on property
- ☐ Cleaning/housekeeping
- ☐ Water & care for plants
- ☐ Conduct or assist with safety inspections
- ☐ Paint
- ☐ Other: ______________________________

____

____

Comments: ____

____

____

Employee Name: ____

Signature: ____
Evaluating Physician

Date: ______________________________

Medical Release of Information

I, ____ hereby release my
(Print Name)

treating Physician, ____
(Print Physician's Name)

to give my employer pertinent information about my current work-related injury/illness and how that injury may affect my ability to perform the essential functions of my job. No other confidential medical information may be released without my written consent. This release will be valid no longer than 90 days, at which time it will be re-evaluated. Any medical information obtained will only be used in the return-to-work program, and there will be no release of medical information from the employer's file.

____ ______________
Injured Employee's Signature Date

____ ______________
Employer's Signature Date

Notice of Modified Duty Available

Date

Employee's Name
Address
City, State & Zip Code

Re: Notice of Employment under the Return-to-Work Program
CERTIFIED MAIL RETURN-RECEIPT REQUESTED

Dear Employee:

Alberta Professional Services, Inc has a transitional work assignment available for you until your physician releases you to a full work status in accordance with our Early Return to Work Program.

Your transitional work assignment will last **(state the length of time)**. The position is in the **(state the department)** where you will **(explain job duties)**. The job entails **(describe the maximum physical demands of the position)**.

Your Physician, **(Physician's name)** has authorized your return-to-work in this job and has agreed that this work assignment is within your physical limitations. Attached is a copy of his/her release (**Return to Work Capabilities Form & Transitional Duty Task List**). We agree to follow the advice of your Physician until you are released to full duty.

Your work schedule will be **(hours)**, on **(days of the week)** and you will be expected to report to **(location and name of supervisor)**. Your rate of pay will be $**(rate)** per **(hour, week, or month)**. If you do not accept the offer, adjustments in your compensation benefits may be made, based on the earnings this transitional assignment would provide.

We look forward to seeing you on **(date)**. If you have any questions, please call us at **(phone number)**.

Sincerely,

President/CEO

Cc: (**Employee's Supervisor)**
Synergy Claims Adjuster
HR Department

I have read and understand the above information.

☐ I accept this job ☐ I decline this position

____ ____________________
Employee Signature Date