

 <b>Missouri Department of Natural Resources Administrative Policies and Procedures</b>		
<b>Chapter 5 Employee Benefits Temporary Modified Duty Policy</b>		
<b>Temporary Modified Duty Procedures</b>	<b>Effective date</b>	<b>Revised</b>
<b>Number: 5.10-01</b>	<b>November 15, 2002</b>	

**REFERENCES**

Missouri State Employee’s Retirement System (MOSERS) - Long Term Disability Plan Handbook and Long Term Disability Plan Handbook Supplement

Title 1, Americans with Disabilities Act

*Related DNR policies:*

- Employee Records 1.03
- Leave with Pay 5.01
- Leave without Pay 5.02
- Family and Medical Leave Act 5.03
- ShareLeave 5.04
- Workers’ Compensation 5.09

*Related Divisional policies:*

Division of State Parks Temporary Modified Duty Policy and Procedures

**DEFINITIONS**

*Attending physician:* The employee’s regular physician following the guidelines and policies of the employee’s insurance carrier.

*Treating physician:* The physician selected or approved by the Office of Administration’s Central Accident Reporting Office under the provisions of the Workers’ Compensation Act.

**GENERAL PROVISIONS**

These procedures outline steps and options to develop a temporary modified duty plan. They can be used for situations where the employee sustains a work related or non-work related injury.

**Work related or Workers’ Compensation situations**

For work related injury covered under Workers’ Compensation, the treating physician authorizes temporary modified duty. This includes the beginning date and the duration of the temporary

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modified duty. The physician’s information can be confirmed with the Central Accident Reporting Office for work related injuries

**Non-work related situations**

For non-work related temporary modified duty, the attending physician provides the program the employee’s restrictions and if possible the program develops a temporary modified work plan. For non-work related injuries the duration of temporary modified duty will not exceed a maximum of 180 calendar days.

The employee must notify their immediate supervisor that they have a temporary medical condition (TMD) that may be affected by his/her work environment, conditions or activities. If the employee cannot perform his/ her usual duties at this time without further risk of injury, the employee should be placed on leave status until a course of action is approved. All efforts should be made to expedite this evaluation period to minimize impacts to the employee and to the department.

**Developing a temporary modified duty plan**

The employee must discuss their job duties and the work environment, conditions or activities with their attending/treating physician so the physician can determine the possible impact on the employee’s medical condition.

The employee must request in writing TMD accompanied by the treating/attending physician’s prognosis, diagnosis and an assessment of the possible impact of the temporary medical condition on the employee’s health. Attachment 1 contains a list of considerations for the physician in developing their assessment and recommendations concerning TMD. The attending physician must sign and date the checklist to indicate concurrence.

The supervisor, with the written request from the employee and the information provided by the physician, shall discuss the employee’s concerns about their work environment, conditions or activities that impact the temporary medical condition. The supervisor will develop a recommendation for temporary modified duty which outlines the position the employee will work in, the work hours and work week, funding source, modified work duties, requested duration of TMD and any other pertinent information.

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The Request for Temporary Modified Duty will be completed (Attachment 2) using the checklist in Attachment 1 to develop the recommendation. Both the supervisor and employee sign the recommendation and checklist. This documentation along with the attending physician’s restrictions is submitted through the supervisory chain of command to the division director or designee for review and approval. The original, signed request is forwarded to the Human Resources Program with copies to the supervisor, employee and for Workers’ Compensation situations, the OA Central Accident Reporting Office.

If the employee does not agree with the approved TMD recommendation, the employee may contact the Human Resources Program or the Employee Relations Office. If the employee refuses Temporary Modified Duty accommodations disciplinary action may be considered. In this situation, for cases pertaining to work-related injuries, the Central Accident Reporting Office is notified.

Once approved, a supervisor will monitor the employee compliance with the temporary modified duties on a regular basis or at least every thirty (30) days.

Employees approved for TMD shall avoid performing duties or activities beyond the scope of the work plan approvals, particularly if other duties may have the potential to prolong the temporary medical condition or cause other injuries. If an employee performs other duties without written approval from his or her treating/attending physician or the division, TMD shall be withdrawn.

During TMD the employee shall report periodically to his or her treating/attending physician. The employee shall provide a written report from the physician to his/her supervisor that includes this information every 30 days during the modified duty assignment. In some instances, this interval may be adjusted to correspond to the physician’s estimated recovery intervals, or in the event of a work-related injury, as specified by the Central Accident Reporting Office. Any adjustments must be clearly identified in the work plan. The treating/attending physician shall provide updated information regarding the employee's functional abilities, physical, psychological or environmental limitations and the employee’s medical restrictions. The treating/attending physician shall also advise the supervisor whether the TMD should be continued; ended, or the employee released to normal work duties. For Workers’ Compensation cases, the “Documentation of Medical Care” form may be used.

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The employee, prior to returning to the normal work assignment, must provide a written confirmation from the treating/attending physician. The physician’s confirmation must clarify that the employee may return to work with or without accommodations.

If an employee is unable to return to regular work duties at the end of the temporary modified duty assignment, the employee may be evaluated for disability eligibility under Title I, American with Disabilities Act. The employee's position will remain unfilled until a final determination is made. During this time, the employee may be placed on sick leave until it is exhausted or other leave options. In the case of a Workers’ Compensation injury or illness, the employee will be reevaluated to determine if Workers' Compensation benefits may continue.

Once these considerations are exhausted, the employee must choose one of the following options:

- Request a permanent transfer
- Request an appropriate leave of absence
- Resign

If the employee does not choose one of the above options, the supervisor may request dismissing the employee through his/her chain of command.

Assistance in implementing these procedures is available from the Human Resource Program, the Employee Relations Officer, or the division’s Human Resources Liaison.

# Attachment 1

<http://n-nr1.nra.ads.state.mo.us/forms/documents/780-2629-temporary-modified-duty-sample-physicians-evaluation.doc>



MISSOURI DEPARTMENT OF NATURAL RESOURCES  
**TEMPORARY MODIFIED DUTY**  
**SAMPLE PHYSICIAN EVALUATION OF EMPLOYEES WORK DUTY CAPABILITIES**

NOTES	
<p><b>These items are by no means comprehensive or the only items that should be considered by a physician. They are offered as suggestions to aid in the development of temporary work duty provisions. Apply these activities to an employee's regular work duties to develop the temporary modified duties.</b></p>	
SAMPLE WORK DUTIES	
<p><b>Lifting</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Maximum pound restriction</li> <li><input type="checkbox"/> Repetitive.</li> <li><input type="checkbox"/> Overhead</li> <li><input type="checkbox"/> Twisting motion</li> <li><input type="checkbox"/> Lifting ____ minutes or hours at a time</li> </ul> <p><b>Mobility</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bending</li> <li><input type="checkbox"/> Repetitive bending</li> <li><input type="checkbox"/> Bending ____ minutes or hours per day</li> <li><input type="checkbox"/> Stooping</li> <li><input type="checkbox"/> Repetitive stooping</li> <li><input type="checkbox"/> Stooping ____ minutes or hours per day</li> <li><input type="checkbox"/> Standing</li> <li><input type="checkbox"/> Standing ____ minutes or hours per day</li> <li><input type="checkbox"/> Crawling</li> <li><input type="checkbox"/> Driving in the usual assigned vehicle</li> <li><input type="checkbox"/> Driving ____ minutes or hours per day</li> <li><input type="checkbox"/> Riding in the usual assigned vehicle</li> <li><input type="checkbox"/> Riding tractors, mowers etc.</li> <li><input type="checkbox"/> Riding ____ minutes or hours per day</li> <li><input type="checkbox"/> Sitting</li> <li><input type="checkbox"/> Sitting ____ minutes or hours per day</li> <li><input type="checkbox"/> Climbing a ladder (step or extension styles)</li> <li><input type="checkbox"/> Height restrictions for climbing</li> <li><input type="checkbox"/> Walking, outdoor, uneven terrain, hills</li> <li><input type="checkbox"/> Walking, indoors, various flooring</li> <li><input type="checkbox"/> Walking, indoors smooth, even surfaces</li> <li><input type="checkbox"/> Walking, hard surfaces</li> <li><input type="checkbox"/> Walking ____ minutes or hours per day</li> </ul>	<p><b>Environment Considerations</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Temperature, cold or hot</li> <li><input type="checkbox"/> Humidity, high or low</li> <li><input type="checkbox"/> Fumes or smoke</li> <li><input type="checkbox"/> Other weather conditions</li> </ul> <p><b>Sensory Considerations</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dexterity</li> <li><input type="checkbox"/> Vision restrictions</li> <li><input type="checkbox"/> Voice restrictions</li> <li><input type="checkbox"/> Hearing restrictions</li> <li><input type="checkbox"/> Noise restrictions</li> <li><input type="checkbox"/> Balance on docks, scaffolds or roofs</li> </ul> <p><b>Medication, medical devices and mental health considerations</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Medications, work restrictions</li> <li><input type="checkbox"/> Allergies, reactions to cleaners, solvents, etc.</li> <li><input type="checkbox"/> Contagious medical conditions</li> <li><input type="checkbox"/> Medical device work restrictions (casts, braces, wheel chair, etc.)</li> <li><input type="checkbox"/> Altered mental capacity</li> <li><input type="checkbox"/> Altered emotional capacity, altered</li> <li><input type="checkbox"/> Potential side effects of trauma</li> </ul> <p><b>Other –please explain</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/></li> <li><input type="checkbox"/></li> <li><input type="checkbox"/></li> <li><input type="checkbox"/></li> </ul>
SIGNATURES	
PHYSICIAN SIGNATURE	DATE
EMPLOYEE SIGNATURE	DATE
SUPERVISOR SIGNATURE	DATE

**EXAMPLE OF ASSIGNMENTS USING ITEMS IN THE EVALUATION CHECKLIST (ATTACH ADDITIONAL PAGES AS NECESSARY)**

Potential Assignment #1: Conduct restroom surveys preparing a list of tasks necessary to have the restrooms fully repaired and operational for \_\_\_\_\_.

**YES NO**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Stooping to gather information concerning restroom repairs such as painting, etc.         |
| <input type="checkbox"/> | <input type="checkbox"/> | Crawling to gather data on pipe and construction repairs.                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Bending to search for data on repairs.  |
| <input type="checkbox"/> | <input type="checkbox"/> | Driving a truck/car short distances to gather restroom repair information.                |
| <input type="checkbox"/> | <input type="checkbox"/> | Sitting at a desk for several hours preparing materials lists and seeking telephone bids. |
| <input type="checkbox"/> | <input type="checkbox"/> | Driving to town to purchase materials at several local vendors.                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Lifting and loading supplies. Include weight limits, if any.                              |

Potential Assignment #2 :

**YES NO**

- |                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |

Potential Assignment #3 :

**YES NO**

- |                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |

Potential Assignment #4 :

**YES NO**

- |                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |

## Attachment 2 Temporary Modified Duty Request

<http://n-nr1ntra.ads.state.mo.us/forms/documents/780-2645-temporary-modified-duty-request.doc>



MISSOURI DEPARTMENT OF NATURAL RESOURCES  
HUMAN RESOURCES PROGRAM  
**TEMPORARY MODIFIED DUTY REQUEST**

EMPLOYEE INFORMATION		
EMPLOYEE'S LAST NAME	EMPLOYEE'S FIRST NAME	EMPLOYEE'S M.I.
DIVISION	PROGRAM OR DISTRICT/SECTION OR PARK/SITE	
TELEPHONE NUMBER WITH AREA CODE	SUPERVISOR NAME	
CARO NUMBER (FOR WORKERS' COMPENSATION SITUATIONS)	DATE OF INJURY	DATE RETURNED TO TEMPORARY MODIFIED DUTY
ASSIGNMENT INFORMATION		
ASSIGNMENT EFFECTIVE DATE		ASSIGNMENT END DATE
ASSIGNMENT IS (CHECK ONE)		
<input type="checkbox"/> FULL TIME WORK SCHEDULE <input type="checkbox"/> PART TIME WORK SCHEDULE		
_____ HOURS PER DAY      _____ HOURS PER WEEK		
<p>Use the <a href="#">Sample Physicians Evaluation of Employees Work Duty Capabilities checklist</a> to outline assigned duties. Include additional pages as necessary.</p>		
SUPERVISOR ACKNOWLEDGEMENT		
<p><b>I have designed this assignment based on the treating/attending physician's temporary medical restrictions.</b></p>		
SUPERVISOR SIGNATURE		DATE
EMPLOYEE ACKNOWLEDGEMENT		
<p><b>I have read and understand the physician's temporary medical restrictions. I have read and understand this temporary assignment. I agree to work within the restrictions identified. If I have any questions or feel I am being asked to work beyond these restrictions, I will notify my supervisor immediately.</b></p>		
EMPLOYEE SIGNATURE		DATE
FOR OFFICE USE ONLY		
<p>_____ ORIGINAL TO DNR HUMAN RESOURCES PROGRAM            _____ COPY TO SUPERVISOR            _____ COPY TO EMPLOYEE            _____ COPY TO OA RISK MANAGEMENT/CARO FOR WORKERS' COMPENSATION SITUATIONS</p>		

MO 780-2645 (04-16)

**This form must be completed, signed and returned to the supervisor prior to the start of temporary modified duty.**