Early & Safe Return to Work Offer

McMaster University has Return to Work Program (RMM #1002) to assist you recover and return to work following your workplace injury. Below is the University's offer of Modified Work Plan.

Employee Name: _____ Date: _____

As a result of injury/illness that occurred on (date): _____

Modified Work Plan to Start On (date): _____ Area of Injury: _____

STANDARD PRECAUTIONS TO BE PROVIDED BASED ON AREA OF INJURY NOTED ABOVE:

☐ **Back:**	☐ **Neck:**	☐ **Shoulders:**	☐ **Upper Extremity:**	☐ **Lower Extremity:**
• Avoid repetitive trunk movement (bending/twisting). • Weight limitation for lifting: no more than 5 lbs. • Avoid prolonged weight bearing (walking/standing). • Avoid low level work. • Avoid heavy pushing or pulling, no more than 5 lbs. • No above shoulder level work. • Ability to sit/stand and take breaks as required.	• Avoid repetitive neck movement. • Avoid above shoulder level activity. • Weight limitation for lifting: no more than 5 lbs.	• Avoid repetitive shoulder activity. • Weight limitation for lifting: no more than 5 lbs. • Avoid above shoulder activity. • No repetitive use of the upper extremity against resistance (pushing/pulling).	• Avoid repetitive movement of the joint against resistance including twisting, pulling and pushing. • Weight limitation for lifting: no more than 5 lbs.	• Avoid repetitive movement of the joint against resistance. • No prolonged weight bearing (walking/standing). • No rough ground walking. • No low level activity • No climbing of stairs and ladders. • Ability to sit/stand and take breaks as required.

MODIFIED DUTIES (specific duties, hours of work, etc. as applicable):

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- *If you experience difficulties performing the Modified Work Plan provided, please contact your Supervisor. Alternate duties will be provided to you.*
- Changes in the above noted Modified Work Plan may occur once updated functional abilities are provided to the University.

Modified Work Plan will be reviewed on (date): _____

Please return a signed and dated copy of this Modified Work Plan to Employee Health Services, retain a copy for your records, and indicate with a check mark whether the Employee accepts or declines this offer of modified work.

_____	Accept ☐	_____
Employee Name (please print)		Supervisor Name (please print)
_____	Decline ☐	_____
Employee Signature		Supervisor Signature
_____		_____
Date		Date