CareWorks

Transitional Work Program Form | BWC TWB-2 Compliant

Company Name: _____

BWC Policy Number: _____

Employee Name: _____

BWC Claim Number: _____

Date of Injury: _____

Job Title: _____

The Transitional Work Program at _____ (Company Name) is designed to provide you with temporary work assignments within your current restrictions per your physician. All parties agree that during your participation in the TWP, you will not be required to perform any tasks or duties that are not compatible with the temporary restrictions your doctor has provided. On _____ (date) your physician _____ (name) provided the following restrictions beginning _____ (date).

1. _____
2. _____
3. _____

Based on the physician defined restrictions, _____ (company name) has work available, starting _____ (date) at _____ (time) working _____ (days of week) from __-__ (hours) doing the following:

_____

_____

_____

This program will continue as long as there is a documented medical need up to a maximum of __ (number of days) days. Your program may be closed earlier due to lack of medical necessity, lack of progress, non-compliance, or other changes in your medical condition.

You will be paid your regular rate of pay for the hours worked while participating in the program. You will be expected to follow all established personnel policies and procedures. Any physical therapy, doctors' appointments, etc. related to your injury or illness are to be scheduled during non-working hours. If you are unable to schedule an appointment during non-working hours, they must be scheduled for the first two or last two hours of your assigned shift. You may receive physical/occupational therapy services at the job site.

EMPLOYEE AGREEMENT

○ I Agree ○ I Disagree (check one)
to participate in transitional work activities within the restrictions indicated by my treating physician. I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Employee Name	Employee Signature	Date Signed

EMPLOYER ACKNOWLEDGEMENT

I certify the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both.

Employer Name	Employer Signature	Title	Date Signed

PHYSICIAN SIGN OFF

By signing below, the physician of record agrees with the above defined restrictions and work responsibilities and releases the injured employee to work as described.

Physician Name	Physician Signature	Date Signed