

McMaster University Early & Safe Return to Work Offer

Employee Name: _____

Date: _____

McMaster University has an Early & Safe Return to Work program in place to assist you while you recover from your workplace injury.

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

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

STANDARD PRECAUTIONS:

<input type="checkbox"/> Back: <ul style="list-style-type: none"> • 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. 	<input type="checkbox"/> Neck: <ul style="list-style-type: none"> • Avoid repetitive neck movement. • Avoid above shoulder level activity. • Weight limitation for lifting: no more than 5 lbs. 	<input type="checkbox"/> Shoulders: <ul style="list-style-type: none"> • 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). 	<input type="checkbox"/> Upper Extremity: <ul style="list-style-type: none"> • Avoid repetitive movement of the joint against resistance including twisting, pulling and pushing. • Weight limitation for lifting: no more than 5 lbs. 	<input type="checkbox"/> Lower Extremity: <ul style="list-style-type: none"> • 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 (list specific duties, hours of work, etc. as applicable):

-
-
-
-

- Transportation to and from work will be reviewed on a case by case basis.
- *If you experience difficulties with any of the modified duties provided, please contact your Supervisor. Alternate duties will be provided to you.*
- Changes in the Modified Duties Plan may occur once updated functional abilities are received.

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

No Review Required, returning to regular duties on (date): _____

Employee Name (please print)	Supervisor Name (please print)
Employee Signature	Supervisor Signature
Date	Date