

## JCBA Common Disability Benefit Plan Package Rehabilitation Provisions

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1. In the event that an eligible employee becomes incapacitated through accident or sickness and s/he is unable to perform all the duties of his/her own occupation, the following shall apply:

- (a) For the purpose of this section, incapacity shall mean where the employee is unable to perform all the duties of his/her own occupation as defined in this document.
- (b) Where the employee meets the definition, the employer shall provide the employee with an application for alternative suitable employment. An employee who fails to:
  - (i) sign the application form;
  - (ii) make themselves reasonably available and co-operate with a reasonable rehabilitation/return to work process consistent with rehabilitation committee principles;
  - (iii) actively engage in a treatment program where the employee's physician determines it to be appropriate to be involved in such a program;

...shall have benefits suspended.

Prior to having benefits suspended, an employee shall be afforded an opportunity to demonstrate that there were reasonable grounds for failing to meet the above obligations.

- (c) The application shall be completed and returned to the employer who shall within 10 work days forward the application to the secretary of the rehabilitation committee. The rehabilitation committee members shall be provided with copies of the application.

2. The rehabilitation committee will, based on the information, coordinate the necessary medical and/or vocational assessments and determine the following:

- (a) if the application is properly before the committee;
- (b) based on the assessment, determine whether the employee is immediately capable of performing modified, alternative or rehabilitative employment;
- (c) if no to (b) above, the committee may, based on the assessments, implement the necessary training to place the employee in alternative or rehabilitative employment;
- (d) In considering modified, alternative or rehabilitative employment, the committee may provide advice and make recommendations to the employer to return the incapacitated employee to work considering the following accommodations:

- (i) modification of the duties of the employee's job;
- (ii) flexibility in scheduling hours of work within existing hours of operation;

## JCBA Common Disability Benefit Plan Package Rehabilitation Provisions

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- (iii) provision of technical or mechanical aids.
- (e) Where the employee is considered capable of performing alternative employment or once the rehabilitative employment is considered to be successful, and the employee is therefore able to perform the duties of a gainful occupation, s/he shall be subject to the provisions of the employee's collective agreement pertaining to priority placement, severance, salary protection and related articles excluding displacement options).
3. An employee in receipt of short term disability (STD) benefits, whose prognosis for return to work exceeds eight weeks, may be referred to the rehabilitation committee if it is medically appropriate to do so.

In those cases where a return to his/her own occupation is unlikely, either party may refer employees to the rehabilitation committee while on short term disability (STD). In such cases, items 1. and 2. above will apply.

4. Where an employee has a physical occupational illness or injury, the employer will, where feasible, accommodate the employee's incapacity so as to avoid a time loss illness or injury.
5. Where the employer has concerns with a recommendation made in accordance with item 2(d) above, the concern will be reviewed with the rehabilitation committee.

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## JCBA Common Disability Benefit Plan Package Rehabilitation Committee Guidelines

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It is the intent of the employer, union, and Insurer to encourage and facilitate the early return to gainful employment of employees who have been ill or injured. To this end, a rehabilitation committee will be established as follows.

1. The size of the committee will be depend on the size of the institution; however, there shall be equal representation from the union and the employer and a mutually agreed upon chair, if necessary. A secretary may be appointed to assist in the administration of the committee.

In addition, the Insurer shall be a resource to the committee to provide support and expertise on a program of rehabilitation. The insurer will also be party to recommending and approving a program of rehabilitation for an employee eligible for short term disability and/or long term disability benefits.

The Insurer will reimburse reasonable and customary expenses incurred by the employee in connection with an approved program.

2. The committee shall review cases of eligible employees who are no longer capable of performing the duties of their own occupation due to illness or injury.
3. The committee shall also review cases of all employees who have become incapacitated through industrial injury or illness. Following the review of such cases the committee, taking into account the best interests of the employee and the employer, shall make recommendations to the disability management co-ordinator.
4. In the event that the committee is unable to decide upon a recommendation, the matter may be referred to the bargaining principals for final disposition.
5. Where possible, the committee shall meet not less than once a month during working hours, and leave without loss of pay shall be granted to committee members. Minutes of the meetings shall be distributed to the union and the employer.
6. The committee shall be committed to maintain confidentiality of medical and other information received in their capacity as members.

**Faculty Common Disability Plan  
Statement of Principle  
Joint Rehabilitation Committee Member**

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\_\_\_\_\_ (Institution Name) is requesting that you, as a member of the Joint Rehabilitation Committee (Committee), agree to keep confidential any personal information that is obtained and used for the purposes of performing your duties as a member of the Committee both during and after your term of appointment to the Committee except where otherwise required by law.

Personal Information means any information relating to an identified or identifiable individual, including but not limited to health and financial information.

I agree to the above.

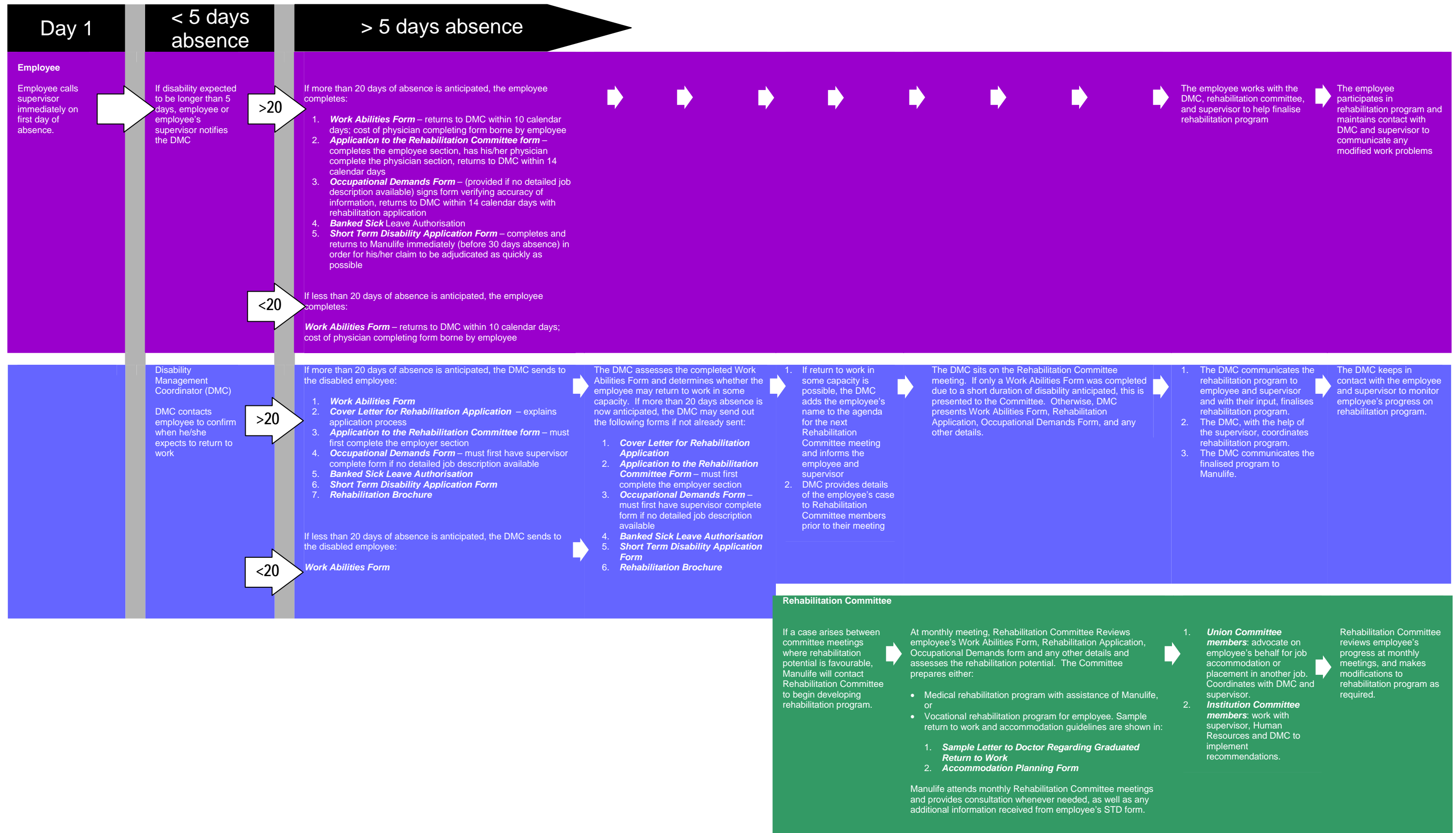
Name: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_

Institution: \_\_\_\_\_

Signature: \_\_\_\_\_

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## Faculty Common Disability Plan Storage of Rehabilitation Files—Privacy Guidelines

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The following guidelines apply to the use, storage and distribution of the rehabilitation application form containing medical data:

- The union and the HR department are responsible for storing the medical data in a rehabilitation committee file, separate from an employee's regular file, that is available only to rehabilitation committee members. The medical information is only to be used to assist the rehabilitation committee in determining whether the employee can return to work and if yes, developing a program that would include his/her restrictions and limitations. Any medical information relating to the employee's disability should be stored in these separate rehabilitation committee files.
- To avoid the unnecessary distribution of a disabled employee's medical information, instead of faxing the completed rehabilitation application form to the union once received, the Disability Management Coordinator should make copies for the next rehabilitation committee meeting where it is distributed and discussed. The union representative and the Disability Management Coordinator will each take one copy to store in their separate and locked rehabilitation committee employee files. (If the union is the BCGEU, the copy of the rehabilitation application will be stored at the BCGEU office at 4911 Canada Way, Vancouver.) All other copies should be collected at the end of the meeting and destroyed.
- Before the rehabilitation committee meeting, each rehabilitation committee member will receive a copy of the agenda and the prior meeting's minutes. At the end of the each meeting, the union representative and the Disability Management Coordinator will take one copy of each document to store in their separate locked rehabilitation committee meeting file. The only documents the committee members may take with them from the meeting are the agenda and meeting minutes.
- The rehabilitation committee case files are to be kept for three years and then destroyed.

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[Date]

[Employee Name & Address]

Dear

**Re: Rehabilitation Committee**

We are sorry to hear that you have experienced an injury or illness that has disrupted your ability to work.

When an injury or illness occurs, we take a series of specific steps to ensure that you receive timely and effective assistance in returning to work. The Rehabilitation Committee (Committee) is established as part of the Faculty Committee Disability Plan. The purpose of the Committee is to determine whether you are capable of alternate suitable work and, if so, to facilitate a return to work as soon as possible.

Please complete the enclosed Application to the Rehabilitation Committee form and return it to me within fourteen (14) calendar days. If you fail to return the application form, you may jeopardise your benefits. Please contact me if you require assistance in completing this form.

Please complete and sign Section A of the form and request your doctor to complete Section C. The completed Section C should be forwarded to me in the envelope provided within 14 calendar days. I have completed Section B and enclose a copy of the job description or occupational demands form for your position. Please provide this job description or occupational demands form to your doctor, as it will assist him/her in assessing your fitness for work.

The Committee will review your application and I will advise you whether your case requires active review. If not, your case may be held in abeyance, pending any change in your current health status.

Should you have any questions concerning this application or your entitlements, please contact me.

You may also wish to contact your Faculty Association or Union Benefits Officer.

Yours truly,

[Institution Disability Management Coordinator]

[Title]

[Contact Information]

Attachment

cc: Union Representative (of BCGEU or FPSE)

# FACULTY COMMON DISABILITY PLAN

## APPLICATION TO THE REHABILITATION COMMITTEE

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Institution

**PLEASE NOTE FOR EMPLOYEES:** All costs for the completion of this Form are the responsibility of the Employer.

### INSTRUCTIONS FOR COMPLETING APPLICATION:

- 1 Section A completed by employee
- 2 Section B completed by employer
- 3 Section C completed by physician

SECTION A – Employee Information		
Name		Date of Birth M    D    Y
Current Address		Postal Code
Home Phone No.	Department	
Work Phone No.	Work Fax No.	
Campus Address		Postal Code
Last Day Worked M    D    Y	Which of the following benefits are you currently receiving? STD <input type="checkbox"/> LTD <input type="checkbox"/> CPP Disability <input type="checkbox"/> WCB <input type="checkbox"/>	Benefit Start Date M    D    Y
WCB Claim No. if applicable		
Physician's Name		
Address: _____		
City _____ Postal Code _____		
Phone No. _____ Fax No. _____		

Employee Feedback (Why are you unable to perform the duties of your position?)

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What aspects of your job do you feel would aggravate your condition?

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### EMPLOYEE AUTHORIZATION

I hereby authorize my physician/specialist, Employer, and any rehabilitative agency to release any relevant information for the purposes of return to work planning to the members of the Rehabilitation Committee. However, this is not an admission that I am able to pursue substantial gainful employment.

Applicant's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

### SUMMARY OF EMPLOYEE'S EDUCATION, TRAINING AND EXPERIENCE

Work/Job Experience – Include Dates and a Brief Description of Duties

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Other Employment Interests

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Other Interests and Hobbies

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List Class(es) of Valid Driver's Licence \_\_\_\_\_ Licence Restrictions \_\_\_\_\_

**ADDITIONAL EDUCATION AND TRAINING**

Describe Secondary, Post-secondary, Courses, and Training  
Start with the highest level achieved and specify the Degrees, Certificates, or Diplomas [ ✓ ]

Name of Institution	Location	Years of Attendance	Area of Study	Certification	Yes	No

**SKILLS / EXPERIENCE**

Check ✓ Areas of Skill

- Word Processing
- Trades/Occupations – Specify \_\_\_\_\_
- Qualifications/Certifications \_\_\_\_\_
- Instructional Experience \_\_\_\_\_
- Curriculum Development/Distributed Learning \_\_\_\_\_
- Computer Systems Software – Specify \_\_\_\_\_
- Computer Systems Hardware – Specify \_\_\_\_\_
- Counsellor/Advisor \_\_\_\_\_
- Administrative Experience \_\_\_\_\_
- Other – Specify \_\_\_\_\_

**SECTION B – EMPLOYER INFORMATION**

1. Please attach a job description to this employer portion of the form. If not available, please complete the attached Occupational Demands Form. If the Occupational Demands Form is completed by the employer, the employee or his/her union representative must verify the accuracy of the information on the form.
2. Please provide background as to what accommodations or actions have taken place to date (training, skill testing, job searches, modified hours/duties, etc.). Please also confirm which supervisor has been involved in this effort to accommodate the employee.

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Disability Management Co-ordinator  
Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

**SECTION C – Physician Information**

**PLEASE NOTE FOR PHYSICIANS:** All costs for the completion of this Form are the responsibility of the employer. Please invoice for BCMA Fee Form A0032, and return with completed forms.

The joint Employer/Union Rehabilitation Committee is designed to encourage and facilitate the early return to gainful employment of employees who have become ill or injured. The Rehabilitation Committee reviews, modifies, and approves your plan. The employer assists the Rehabilitation Committee by making resources available to help employees return to work.

**INFORMATION TO PHYSICIAN**

Your patient has submitted an application to the joint Union/Management Rehabilitation Committee on the basis of a medical condition, which may have rendered him/her currently incapable of performing the duties of his/her occupation. The Rehabilitation Committee has the responsibility for reviewing and approving return to work plans.

Please forward this confidential report to:

Disability Management Co-ordinator

\_\_\_\_\_  
Institution Name and Address

Last Examination Date: \_\_\_\_\_

Are the patient's limitations  Permanent  Temporary

Is this a condition, which will recur?  Yes  No

**SUMMARY OF FINDINGS – INCLUDING PROGRESSION OF DISABILITY**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| 1. Is your patient currently capable of performing all the duties of his/her own occupation as described in the attached job description or Occupational Demands Form? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If no, what limitations or restrictions would you advise for your patient in relation to returning to the job as described?   |                          |                          |

\_\_\_\_\_  
\_\_\_\_\_

- |  |                          |                          |
|--|--------------------------|--------------------------|
| 3. If your patient is unable to return to the job as described, will your patient be able to return to other gainful, productive employment? | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

4. When could rehabilitation or a return to work plan commence?

\_\_\_\_\_

Additional Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Fax No.: ( ) \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_  
Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**EMPLOYEE AUTHORIZATION – I hereby authorize my physicians/specialists to release any relevant information as requested by members of the Rehabilitation Committee for the purposes of return to work planning.**

**Applicant's Signature:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_

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## Sample Letter to Doctor Regarding Graduated Return to Work

[Date]

Dr. \_\_\_\_\_

Re: \_\_\_\_\_  
Graduated Return to Work Schedule

Dear Dr. \_\_\_\_\_,

I am a member of the \_\_\_\_\_ Rehabilitation Committee.

I had the opportunity to meet with your patient, \_\_\_\_\_, on Jan 14/07 at which time we discussed her current status, ongoing treatment, and return to work options. I have also received correspondence regarding your conversation with \_\_\_\_\_. Subsequent to my initial meeting with \_\_\_\_\_, we arranged a return to work meeting that included her supervisor. At that meeting we discussed return to work duties during her graduated return to work schedule as well as a graduated return to work schedule.

Please find below a suggested graduated return to work schedule.

	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
<b>Week of Feb 11</b>	3hrs		3hrs		3hrs
<b>Week of Feb 18</b>	3hrs		3hrs		3hrs
<b>Week of Feb 25</b>	3hrs	3hrs	3hrs	3hrs	3hrs
<b>Week of Mar 04</b>	3hrs	3hrs	3hrs	3hrs	3hrs
<b>Week of Mar 11</b>	5hrs	3hrs	5hrs	3hrs	5hrs
<b>Week of Mar 18</b>	full day	4hrs	full day	4hrs	full day
<b>Week of Mar 25</b>	full day	6hrs	full day	6hrs	full day
<b>Week of Apr 01</b>	full day	6hrs	full day	6hrs	full day
<b>Week of Apr 08</b>	Return to work full time				

Return to work Duties:

As per your conversation with \_\_\_\_\_, I understand that it would be best for \_\_\_\_\_ to return to work initially without supervisory duties. Due to this, \_\_\_\_\_'s, manager has provided an outline of duties and a list of possible additional duties in order to accommodate \_\_\_\_\_'s return to work.

1. During the weeks of Feb 11 and Feb 18, \_\_\_\_\_ will do the following (description of example duties):
  - Compile written comments from the Women's Centre evaluation forms.
    - Input these comments into an electronic document
    - Create categories from the comments and generate conclusions based on the results.
  - Revise the Student Services manual
    - Check that information is current and update where necessary
    - Include additional information to fill any gaps so that a new hire can be fully oriented by reading this manual
    - \_\_\_\_\_ acknowledged that this was a good tool to help her catch up on current procedures and policies.

2. During the weeks of Feb 25 and March 04, \_\_\_\_\_ will do the following:
  - Prepare information related to budget impact on Student Services
    - Specific details will depend on budget information that is to be released by the College President on Feb 19/02
  - Compile and/or revise documents and data in Student Services. This includes letters, information sheets, and documentation.
  
3. During the weeks of March 11 and March 18, \_\_\_\_\_ could do a variety of the following:
  - Information gathering and providing written reports
  - compose and send letters to students who have requested information
  - prepare a report based on results from Safety Audit
  - compile statistics on use of services by students
  - create a pamphlet for \_\_\_\_\_
  - prepare revisions to the student services website

\_\_\_\_\_’s manager has indicated that some additional duties will be decided as the schedule progresses but reported that at a point it will become increasingly difficult to find productive and meaningful work for \_\_\_\_\_ to do. In light of that I would like to request your opinion on when \_\_\_\_\_ could begin to resume her supervisory duties. \_\_\_\_\_’s manager has indicated that due to the number of people involved and displaced, he will need a two (2) week notice to make the arrangements with other departments. In addition, he felt that she would benefit from job shadowing the ‘acting supervisor’ for about a week during the transition. At this time I would like to make the recommendation that \_\_\_\_\_ begin to add supervisory duties and job shadow for the 2 weeks of March 25 and April 01.

Currently, \_\_\_\_\_’s employer is trying to make arrangements for secure office space for her. However, office space is limited and the result may be that she will have to rotate through available offices. \_\_\_\_\_’s regular office will not be available until she is able to return to her regular duties. \_\_\_\_\_ has indicated sensitivity to fluorescent lighting and at this time we are trying to make appropriate accommodations to address her concerns.

Could you please sign the bottom of this letter to acknowledge that you agree with the above return to work plan. In addition, could you indicate when \_\_\_\_\_ would be able to resume her supervisory duties if different than the weeks of March 25 and April 01. I have also provided room at the bottom of this letter for your comments, amendments, and/or suggestions. I have discussed the contents of this return to work proposal with \_\_\_\_\_.

If you have any questions, comments, and/or suggestions, please do not hesitate to call me at [phone number].

Sincerely,

\_\_\_\_\_

cc. \_\_\_\_\_ Case Manager, Manulife Financial

Dr. \_\_\_\_\_

\_\_\_\_\_ Date

Date to resume supervisory duties: \_\_\_\_\_

Comments:

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October 2007

## ACCOMMODATION PLANNING FORM

Employee's Name \_\_\_\_\_ Date Prepared \_\_\_\_\_

Plan Objective \_\_\_\_\_ Plan Completion Date \_\_\_\_\_

Target Date	Actions/Modifications/Supports	Person Responsible
1.		
2.		
3.		
4.		
5.		

This plan outlines the activities and responsibilities of all participants, with the goal of promoting recovery and helping the employee to return to work

### Signatures

Employee \_\_\_\_\_ Date \_\_\_\_\_

Manager/Supervisor \_\_\_\_\_ Date \_\_\_\_\_

Union (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

Human Resources \_\_\_\_\_ Date \_\_\_\_\_

**Revisions** \_\_\_\_\_ **Date/Initials** \_\_\_\_\_

### **The Benefits Carrier**

The carrier (Manulife Financial):

- Determines whether you are medically eligible to receive STD/LTD plans.
- Issues bi-weekly benefit payments to employees they have accepted for benefits.
- Reviews claims files on a regularly scheduled basis.
- May recommend a program of rehabilitation.

### **Rehabilitation Committee**

The Rehabilitation Committee consists of representatives from your union and your employer.

The committee has been designed to help you return to gainful employment, whether it's your own occupation or an alternate one. The committee reviews and approves your return to work plan and makes recommendations to your department as your rehabilitation progresses. All information provided to the rehabilitation committee is considered **strictly confidential**.

If you cannot return to your own job, the committee may arrange the necessary funding and/or training to place you in rehabilitative employment in another occupation. When the

training is completed, you may be referred for a priority placement in the organisation according to the provisions of the collective agreement pertaining to priority placement (if applicable).

This is a mandatory program. There is no guarantee of placement; therefore, it is imperative you cooperate fully with the Rehabilitation Committee in your endeavour to return to work. The earlier you participate in the program, the better your chances are of returning to work.

### **Employer Rehabilitation Committee Representative**

- Attends Rehabilitation Committee meetings as the designated representative.
- Receives progress reports about your rehabilitation and reviews this information with the other Rehabilitation Committee members.
- Works with your supervisor or Human Resource Advisor and you to implement the recommendations.

### **Union Rehabilitation Committee Representative**

- Your union acts as your representative on the Rehabilitation

Committee and has an important role in the rehabilitation process.

- Advocates on your behalf for job accommodation or placement in another job.
- Makes recommendations to your employer regarding your return to work plan on your behalf, which includes providing suggestions to workplace changes.
- Reviews progress reports about your rehabilitation and maintains a dialogue with other Rehabilitation Committee members concerning it.

### **WorkSafe BC**

- Works with the Rehabilitation Committee to provide assessment and rehabilitation services for employees on WCB claims.

### **For Further Information**

Please contact your supervisor, your Disability Management Co-ordinator, or your Union.

REHABILITATION  
AND  
RETURNING TO WORK  
FOLLOWING AN ILLNESS  
OR INJURY

EMPLOYEES COVERED UNDER  
THE COMMON AGREEMENT  
DISABILITY

**This brochure outlines the general process of returning to work following an illness or injury for eligible employees covered under the disability plans under the Common Agreement. The intent is to help you return to work as soon as possible after you have been ill or injured.**

### **Your Responsibilities as an Employee**

The single most important person in the rehabilitation process is you, the employee. Without an understanding of what you can do yourself, and your motivation to return to work, any rehabilitation efforts will be made more difficult.

### **Sick Leave**

For the first thirty (30) calendar days of absence due to illness, you will receive 100% of pay.

### **Short Term Disability**

You may receive 70% of pay for an absence due to illness for 21 weeks. Each claim is reviewed by an outside insurance carrier.

### **Long Term Disability**

After you have exhausted short term disability, if you are unable to work for medical reasons, you may receive long term disability (LTD) benefits, which is 70% of your earnings at the last day of STD and which may be payable for up to two (2) years and also until you are age 65, provided you meet the criteria.

Each application for LTD is reviewed by an outside insurance carrier who determines you are disabled as defined in the plan.

The carrier is also responsible for paying you benefits and for reviewing your claim on a regular basis.

### **Rehabilitation Steps**

In the process of returning to work, in either your own job or another job, there are a number of steps, which

may be taken. These steps will vary with each employee, but can include:

- Getting written clearance to return to work from your physician.
- Developing a plan with your supervisor for your return to work.
- Returning to your own job or to an alternate position on a trial basis.
- Arranging training for an alternate job, if necessary.

If your physician has recommended you return to work on a gradual or modified basis, or if you are returning from a lengthy illness/injury, you may return on what is called a work trial. This trial gives you the opportunity to refamiliarize yourself with the worksite and build stamina to handle your full job again. There are generally two types of trials; STD trials and LTD trials.

During a STD trial, you receive 100% of your pre-disability earnings\* for all hours worked and STD benefits for any hours you are not at work. STD trials must be reviewed and approved by the Rehabilitation Committee. In no event will you receive more than 100% of your pre disability earnings.

Employees may also return to work while on LTD on a rehabilitative trial basis. During rehabilitative employment, you receive 100% of pre-disability regular earnings for hours worked and LTD benefits for any hours not at work. In no event will you receive

more than 100% of your pre-disability earnings.

Rehabilitative employment is approved by your doctor and by your employer. The nature of your rehabilitative employment is reviewed by the Rehabilitation Committee.

### **Roles and Responsibilities Involved in the Process**

There are a number of people or groups who may become involved in your return

to work, all of whom have specific roles and responsibilities.

### **You, the Employee, are Expected to:**

- Report any absence as soon as possible to your supervisor, giving a reason for the absence and when you expect to return to work;
- Obtain medical clearance to return to work, if needed or requested;
- Submit the required forms for an absence when required to do so;
- Cooperate in the rehabilitation process by working with your supervisor and Human Resource Advisor to develop your return to work plan;
- Participate in a rehabilitative or STD trial return to work when you have been medically cleared to do so.

Most important is that your health recovers and you return to work as soon as possible. The other parties in the process also have clearly defined roles.

### **Your Physician**

Your physician provides consultation, medical opinions, and advice about your ability to attend work and do your own job, or gives clear medical instructions on your ability to do another job.

### **Your Supervisor and Disability Management Co-ordinator**

Your supervisor and Disability Management Co-ordinator work together with you to develop a return to work plan. They co-ordinate your return to work, and will involve other people (such as your physician or Workers' Compensation Board) when required.

They also work along with your physicians and Rehabilitation Committee to assess your limitations and capabilities of returning to work.

### **Human Resources**

Administers the sick leave, STD and LTD benefit plan and review each employee's eligibility to apply for STD and LTD.

- Co-ordinates submission of STD and LTD forms to the benefits carrier.
- Provides advice to your department on general sick leave, STD, LTD, and rehabilitation policies and procedures.

This brochure outlines the general process of returning to work following an illness or injury for eligible employees covered under the disability plans under the Common Agreement. The intent is to help you return to work as soon as possible after you have been ill or injured.

\*Earnings is defined as per the Common Disability Plan