

[COMPANY NAME]

IN CASE OF INJURY
GRAB-N-GO KIT
AN ESSENTIAL PART OF OUR
RETURN TO WORK BENEFIT
PROGRAM

EMPLOYEE INSTRUCTIONS:

This Kit is designed to facilitate care of our employee in the event of a workplace injury. Please review this kit with your medical provider at your initial visit and return all completed documents to [Company Rep] prior to your next scheduled shift.

- Letter to Medical Provider** – [COMPANY NAME] knows that our employees are our most valuable resource and whenever possible we provide medically appropriate alternative work for injured employees while they heal. This brief letter explains our Return to Work program.
- Work Capacity Form** – To be completed by the treating physician at the initial visit and each follow-up if necessary. If an employee is released to full duty this is the only document required from this kit. If the physician deems physical restrictions are appropriate for the existing medical condition, the enclosed job descriptions/analysis should be reviewed by the physician for approval or recommendations if appropriate.
- Job Description/Analysis** - For the medical provider to review the physical requirements of your regular job duties and to approve, or modify and approve, if medically appropriate for your current condition.
- Temporary Transitional Job Description/Analysis** - If original job duties, with or without modification, are deemed too strenuous for your current medical condition, these alternative duties requiring minimal physical activity are available to help you remain productive and maintain regular wages while healing.

For the Supervisor, if accompanying injured employee:

- First Report of Injury (FROI)** – This document is required for filing a workers' compensation claim for this incident and to facilitate timely bill payment. Complete with the facts you have available and return as soon as possible to HR/Personnel for completion and timely submittal to Montana State Fund.
- Initial Investigation Report** – Initiate an investigation into the root causes of this incident so that we may work to prevent any similar future incidents.

Thank you for cooperating with our efforts to maintain a safe, healthy, and productive work environment for our employees. Please contact [COMPANY ADMINISTRATOR] at ### - #### if you have any questions or concerns regarding our Return to Work benefit program.