City of Laredo Human Resources Department
Return to Work Policy

Regular full-time employees who have at least one (1) year of employment with the City of Laredo fall under the Return to Work Policy.

The Serious Illness Program is for illnesses which require daily or continuing treatment as certified by a health care provider and for illnesses/injuries which need convalescence and are of incapacitating nature, such as personal medical illnesses, off the job injuries, surgery, impairment, or physical mental conditions.

To qualify for Serious Illness, employees must be under a medical provider's care for a period of more than five (5) consecutive working days.

Please initial each number.

_____ 1. To qualify for Serious Illness, employees must have completed 6 months of employment.
_____ 2. The Serious Illness program was established by granting one (1) day for each full month of employment.
_____ 3. The request is approved by the department director and the human resources director.
_____ 4. Cosmetic surgery does not qualify for the Serious Illness Program.
_____ 5. Number of serious illness days granted will be based on Official Disability Guidelines comparable to the employee's job duties.
_____ 6. **Failure to provide medical reports to Employee Health & Wellness and failure to comply with all medical recommendations or appointments will immediately terminate the use of the Serious Illness Program.**
_____ **7. If an employee is certified by a health care provider to be off work, the employee is required to submit monthly status reports to Employee Health & Wellness to report the employee's status and intention to return to work.**
_____ **8. Such reports are required at the time of each scheduled visit with the treating health care provider and are due immediately after the visit.**
_____ 9. If an employee is placed on modified duty, assignment shall not exceed a total of 180 work days. If an employee is not released to full duty after 180 days of modified duty, employee will be taken off work and on personal accruals until released to full duty.
_____ 10. After **260 missed work days** from the original date of injury, if the employee is unable to return to work and does not fall under the ADA guidelines, **the employee will be terminated**. **Subsequent intermittent or consecutive follow-ups** as directed by the treating physician for the purpose of the personal medical illness/injury **shall be counted towards the 260th day**.
_____ **11.** The above stated applies except as otherwise stated as per the current **Collective Bargaining Agreement (Fire and Police).**

I _____, SS# (Last 4 digits) _____have received and understood the above explained summation of the **Return to Work Program.**

_____ _____ _____
Employee Signature Date Time

_____ _____ _____
Explained/Witnessed by Date Time

CITY OF LAREDO

HUMAN RESOURCES DEPARTMENT

EMPLOYEE HEALTH & WELLNESS DIVISION

This document is confidential and is to be ready by the addressee only.

FOR APPROVAL OF SERIOUS ILLNESS POOL

Please submit the diagnosis/prognosis for the following employee regarding their medical condition to the City of Laredo Employee Health & Wellness Division. If you have any questions, please call Employee Health & Wellness at 956-727-6470.

TO: _____

Treating Physician

NAME: _____ DATE: _____

SS#: _____

DIAGNOSIS: _____

ICD 9: _____

ICD 10: _____

DATE OF SERIOUS ILLNESS: _____

DATE OF SERIOUS INJURY: _____

DATE OF SURGERY: _____

DATE OF INCAPACITATION: _____

RETURN TO WORK DATE: _____

_____

Signature of Treating Physician

Please send originals to: **Employee Health & Wellness**
1102 Bob Bullock Loop
Laredo, TX. 78043

Ph: (956) 727-6470 **Fax:** (956) 727-6472

EMPLOYEE ON LEAVE – HR DIVISION CHECKLIST

Employee Name: Last	First	MI
Employee. #:	Contact Phone #:	
Department:	Email:	

Place a ☑ to the event that occurred

Type of Leave	☐ Personal Illness	☐ Workers Comp	☐ Maternity Leave	☐ Military Leave	☐ Other: _____
Date of Occurrence					

Accruals as of date: _____

Accrual	Comp Time	Personal Holiday	Sick Leave	Vacation	Wellness Day
Hours					

Employee Notice of Responsibilities

City of Laredo Employee,

When you are not ***"actively at work"*** for an extended period of time for any type of paid or unpaid leave your benefits may be affected.

Date of Notice: _____

Employee Wellness Clinic	
☐ Explanation of Accruals ☐ Other: _____	Employee Initials: _____ Staff Initials: _____

Health & Benefits	
☐ Acknowledgement of Insurance Payments Form ☐ Disability Claim Forms (if applicable)	Employee Initials: _____ Staff Initials: _____

Risk Management	
☐ Explanation of Benefit Waiting Check ☐ No lost time (if applicable)	Employee Initials: _____ Staff Initials: _____

Instructions: Once all divisions complete the Notice of Responsibilities with the employee, supply the employee with a copy and keep the original blue form with Health & Benefits for record keeping purposes.