

## **TEMPORARY ALTERNATIVE WORK PROGRAM (TAWP) INFORMATION AND PROCEDURES**

The University of New Hampshire provides a Temporary Alternative Work Program for staff, faculty, and student employees who have been ill or injured and who are unable to return to full duty. The program allows for the employee to be assigned temporary alternative work.

In the attached packet, you will find information and forms to assist you in following the correct procedures when an employee who has been ill or injured has been released to return to work with some medical restrictions. Please read all information carefully and direct questions to the HR Workers Compensation Coordinator.

### **Temporary Alternative Work Program forms:**

- **Status Form** – The injured employee must take this form to the treating physician. The physician will use this form to indicate whether the employee must be off work, may work with restrictions, or may return to full duty. The employee should take the status form to the physician at each scheduled visit in order for the physician to certify the employee's continued need to be off work or for temporary alternative duty. The employee must return the completed status form to his/her supervisor within one working day following each visit with the physician.
  
- **Temporary Alternative Work Description** – The temporary alternative work department supervisor will work in conjunction with the Workers' Compensation Coordinator and the UNH Occupational Health & Safety Coordinator to complete this form. The physician will review and make any necessary changes and/or recommendations. If the essential functions of the temporary assignment must be changed, the temporary alternative work supervisor will determine whether the restrictions can be accommodated. If not, the department may withdraw the offer or try to make other modified/alternative duty arrangements.
  
- **Temporary Alternative Work Assignment Agreement** – The temporary alternative work department supervisor must complete this form once the treating physician and the supervisor have agreed upon a temporary assignment job description. The employee must formally accept or reject the temporary alternative work assignment agreement. **Note: An employee who is offered such a position and is certified by their physician as capable of performing the required job duties must accept the offer or risk disciplinary action including termination.**

**TEMPORARY ALTERNATIVE WORK PROGRAM**  
**Status Form**

**TO:** Examining Health Care Provider                      **SUBJECT:** Employee: \_\_\_\_\_  
**FROM:** University of New Hampshire                      **SS#:** \_\_\_\_\_  
**DATE:** \_\_\_\_\_

---

We want to assist our employee and your patient to return to work as soon as possible and assist him/her in performing essential job functions at this institution. The information you provide on this form is vital and will be used for the following considerations:

- Allow the employee to work without risk of further injury;
- Revision of a temporary assignment if necessary that meets the employee's needs and the needs of this institution;
- Provision of any temporary reasonable accommodations to aid the employee in performing his/her duties.

The employee's Temporary Alternative Work Description is attached for your consideration:  
\_\_\_\_\_ Regular Job Description                      \_\_\_\_\_ Temporary Alternative Work Assignment

If you have any questions regarding the information requested on this form, please contact:

\_\_\_\_\_  
Name & Title of Temporary Alternative Work Department Supervisor                      Telephone Number

---

**TO BE COMPLETED BY HEALTH CARE PROVIDER**

Considering this employee's job duties and health condition, this employee may perform work in the following manner:

\_\_\_\_\_ Full Duty (no restrictions)  
\_\_\_\_\_ Regular Job Description                      Beginning: \_\_\_\_\_

\_\_\_\_\_ Less than Full Duty (some restrictions)                      Beginning: \_\_\_\_\_  
\_\_\_\_\_ Temporary Assignment Job Description  
Additional Restrictions to Temporary Alternative Work assignment should be noted on the  
Temporary Alternative Work Description Form.

\_\_\_\_\_ No Work until Re-evaluated by Physician                      Beginning: \_\_\_\_\_  
Next Office Visit Scheduled: \_\_\_\_\_

\_\_\_\_\_  
Health Care Provider's Signature

\_\_\_\_\_  
Date

Employee Name: \_\_\_\_\_  
Position Name: \_\_\_\_\_

Temporary Alternative Work Department: \_\_\_\_\_  
Effective Date: \_\_\_\_\_

**Essential Functions:** (Supervisor: List essential job functions. Health care provider: Indicate if the employee can/cannot perform the essential function listed by circling yes or no.)

_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No

**Physical Requirements:** (Supervisor: Check those that apply to job described above. Health care provider: Check yes or no)

<b><i>Requirement:</i></b>	<b><i>Yes</i></b>	<b><i>No</i></b>	<b><i>Requirement:</i></b>	<b><i>Yes</i></b>	<b><i>No</i></b>
___ Lifting			___ Walking	___	___
___ Moderate(15-45 lbs)	___	___	___ Standing	___	___
___ Light (up to 15 lbs)	___	___	___ Sitting	___	___
___ Carrying			___ Crawling	___	___
___ Heavy(45 lbs and up)	___	___	___ Twisting	___	___
___ Moderate(15-45 lbs)	___	___	___ Pushing	___	___
___ Light (up to 15 lbs)	___	___	___ Stooping	___	___
___ Reaching above shoulders	___	___	___ Kneeling	___	___
___ Straight pulling	___	___	___ Ability to read	___	___
___ Pulling hand over hand	___	___	___ Ability to type	___	___
___ Dual simultaneous grasping	___	___	___ Ability to write	___	___
___ Operating mechanical equipment			___ Hearing	___	___
Specify _____	___	___	___ Speaking	___	___
___ Operating office equipment			___ Climbing stairs	___	___
Specify _____	___	___	___ Simple grasp	___	___
___ Operating a motor vehicle	___	___	___ Repeated bending	___	___
___ Other: _____	___	___			

□Wal

**Additional Recommendations/Restrictions:** (Health care provider: List if applicable)

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

**Doctor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor's Printed Name:** \_\_\_\_\_

**Approval of TAWP department:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**University of New Hampshire**  
**TEMPORARY ALTERNATIVE WORK PROGRAM**  
**Temporary Work Agreement**

**Date:** \_\_\_\_\_  
**To:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**From:** \_\_\_\_\_ Temporary Alternative Work Department Supervisor  
\_\_\_\_\_ Human Resources Representative

Temporary Assignment Position Name: \_\_\_\_\_

Specific Duties and Maximum Physical Job Requirements: See attached Temporary Alternative Work Description Form.

Temporary Alternative Work Department: \_\_\_\_\_

Temporary Alternative Work Supervisor: \_\_\_\_\_

Temporary Assignment Location: \_\_\_\_\_

Expected Duration:      Begin Date: \_\_\_\_\_      End Date: \_\_\_\_\_

The temporary alternative work assignment will be no longer than eighteen months and will end when you are able to return to full duty as certified by a health care provider or when the temporary alternative work assignment terminates, whichever occurs first.

If you do not choose to accept this temporary alternative work assignment and are absent from work due to a Workers' Compensation approved injury or illness, the New Hampshire Workers' Compensation Law allows for reduction or termination of your temporary income benefits if you are off work due to a Workers' Compensation approved injury or illness.

If your absence is not covered under FMLA provisions and you fail to accept a valid temporary assignment or to continue that assignment as long as certified by your health care provider as physically able to do so, you may be subject to disciplinary action, up to and including termination.

The University of New Hampshire is aware of and will abide by any physical limitations under which the treating health care provider has authorized you to work. **It is your responsibility to inform the University of any change in status or work restrictions as recommended by your treating physician.** You are required to submit a Temporary Alternative Work Status Form to your supervisor within one working day following each visit to the health care provider.

If you have any questions about this temporary assignment position or job modifications, please contact the Workers' Compensation Coordinator at (603) 862-0547.

---

I, \_\_\_\_\_, do hereby understand and formally (\_\_\_\_accept/\_\_\_\_reject) the temporary assignment position outlined above. (If rejected, please provide reason(s) below.) I understand that I must meet the eligibility criteria as outlined in the Temporary Alternative Work Program requirements and must adhere to all of my health care provider's recommendations and the University of New Hampshire's program regarding this temporary assignment. I understand that employees who are offered such a position and are certified by their physicians as capable of performing the required job duties must accept the offer or risk disciplinary action, up to and including termination. I also understand that my Workers' Compensation benefits may be reduced or terminated if I reject this offer. Furthermore, if I have exhausted my paid leave and FMLA entitlements, then I also may face termination.

If you are rejecting the temporary alternative work assignment, please state your reason(s):

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date