Workplace Safety and Loss
Prevention Program
1220 Washington Ave.
Building 12, Room 167
Albany, NY 12226
(518) 485-9766

NEW YORK STATE | Department of Labor
WORKING FOR YOU

Workplace Safety & Loss Prevention Incentive Program
Return to Work Program - Section 1.15
Evaluation Report

An employer must file an application for the Department of Labor's (DOL) approval of a Workplace Safety and Loss Prevention Incentive Program (WSLPIP) credit. The application must include an Evaluation performed by a certified Specialist or the DOL. The Evaluation report will review the required elements of the specific incentive program for which the employer is applying, assess the employer's compliance, and make recommendations for the implementation of the program.

Date of Evaluation: ___ / ___ / _____ Date of report: ___ / ___ / _____

Implementation date of Return to Work Program: ___ / ___ / _____

Section A: Employer Information

Company name: _____

Company address: _____

City: _____ State: _____ Zip code: _____ NAICS: __ __ __ __ __ __

Contact person: _____

Title: _____ Email address: _____

Phone number: (_____) _____ - _____ Number of employees: _____

Federal Employer Identification Number (FEIN): __ __ - __ __ __ __ __ __ __

Section B: Workers' Compensation Insurance Information

Please provide the below information for the workers' compensation policy for which the employer is seeking the incentive credit. Fill out one report per policy.

Insurer: _____

Address: _____

City: _____ State: _____ Zip code: _____

Annual policy renewal date: ___ / ___ / _____ Experience rating (current policy year): _____

Annual insurance premium: _____ Contact person: _____

Title: _____ Phone number: (_____) _____ - _____

Email address: _____ Policy number: _____

Experience rating (previous policy year): _____ ☐ Check box if self-insured

Annual security deposit (if self-insured): _____

Section C: Company Location(s) Information

Enter the physical address for all locations covered by the workers' compensation policy listed above. Use Appendix A to list additional employees.

Company location	Management Contact Name	Management Contact Phone	No. of employees	Employee representative
		(_____) _____ - _____		
		(_____) _____ - _____		
		(_____) _____ - _____		
		(_____) _____ - _____		
		(_____) _____ - _____		

Section D: Employee Representative(s) Information

Use Appendix A to list additional employee representatives.

Employee (#1) representative:	Bargaining unit (if applicable):
Work Location:	Phone number: (_____) _____ - _____
Employee (#2) representative:	Bargaining unit (if applicable):
Work Location:	Phone number: (_____) _____ - _____
Employee (#3) representative:	Bargaining unit (if applicable):
Work Location:	Phone number: (_____) _____ - _____

Section E: Synopsis of Employer

Describe the employer's primary business activity at the locations in which the program has been implemented.

Section F: Review of Employer Return to Work Program

An acceptable Return to Work Program facilitates an employee's return to work as soon as medically possible after a job-related injury or illness. A Return to Work Program provides fair and consistent practices for accommodating the needs of employees who have become ill or injured on the job or have sustained a temporary or permanent partial disability covered by the Workers' Compensation Law in order for such employees to make a timely and safe return to work. The final, approved Return to Work Program plan shall be provided to the designated employee representative(s) in each workplace location or to the recognized representative of each collective bargaining unit, where applicable, and shall be made available to all employees upon request

Program Element #1
An employer's statement of commitment to providing safe, gainful, and meaningful employment to employees as soon as medically possible following an on-the-job injury or illness.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #1? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #2
A plan for communication with all parties, including the injured worker, the treating physician, the collective bargaining representative, if any, and the Board, in order to facilitate an employee's return to work. The communication must be made in accordance with applicable privacy laws.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #2? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #3
A policy and procedure for returning injured employees to the workplace that is communicated to all employees and collective bargaining representatives in writing and in a timely manner.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #3? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #4
Policies and procedures that focus on returning the employee to his or her pre-injury employment in a safe and timely manner, accommodating the needs of that employee concerning a position with the employer, and which do not cause undue hardship on the parties or violate an existing collective bargaining agreement.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #4? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #5
A policy and procedure for ensuring the involvement of the injured or ill employee in all aspects of the return to work process.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #5? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #6
A policy and procedure for ensuring the involvement of one or more designated representatives of employees and/or the recognized representative(s) of each collective bargaining unit, where applicable, in the Return to Work Program.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #6? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #7
A policy and procedure for ensuring that the injured employee's treating physician is, in a timely manner, given information which will assist in determining the injured worker's ability to return to the pre-injury job, a modified job, or a suitable alternative work assignment at the employer.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #7? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #8
A process for the development and implementation of a written individual return to work plan for each injured or ill employee, developed by the employer, the employee and the designated representative(s) of employees and/or the recognized collective bargaining representative, where applicable.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #8? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #9
A policy to return an injured worker to the pre-injury job as soon as it is medically determined by the treating physician that the employee is capable of performing the essential duties of their pre-injury or pre-illness job.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #9? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #10
A policy and procedure to make reasonable efforts to accommodate the employee's work-related injury or illness so that the post-injury job is consistent with an assessment by the worker's treating physician, with the goal of offering the employee alternative suitable and available work that is comparable in nature and earnings to the worker's pre-injury job.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #10? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #11
A policy and procedure for referring an employee to a vocational assessment and for providing vocational services if the injured or ill employee cannot safely perform the essential duties of the pre-injury job or a suitable alternative job at the employer.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #11? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #12
A procedure for monitoring the employee's progress, recovery, and return to work, with notice to the employee's treating physician and the recognized collective bargaining representative, if any.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #12? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #13
Strategies for maintenance and promotion of the program.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #13? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #14
An evaluation component that includes realistic and measurable criteria to determine the appropriateness and effectiveness of the program and an assessment of employee participation in the program.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #14? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Program Element #15

Designation of a Return to Work Program contact at the employer for use by employees seeking to participate in the Return to Work program.

Does this program element meet the Department's requirements? ☐ Yes ☐ No

Did you make any recommendations to implement program element #15? ☐ Yes ☐ No

Please provide an assessment of the employer's compliance with this program element and list any recommendations you made for the program's implementation of this element.

Section G: Additional Elements

Summarize any additional program elements the employer has implemented which were not reported above.

Provide a brief assessment of the program element(s) and list any recommendations you made for the implementation of such program elements(s).

Section H: Additional Evaluation Services

Did you provide other services, training or materials to this employer? _____

Date of Services: ____ / ____ / _____

Briefly outline the additional evaluation services you provided to this employer.

Section I: Opening and Closing

The Specialist must conduct an opening conference with the employer and employee representatives, including the recognized representative of each collective bargaining unit, where applicable, to discuss (i) how they will conduct the Evaluation(s); and (ii) what records and information they need to perform the Evaluation. The Specialist must hold a closing conference with the employer and employee representatives, including the recognized representative of each collective bargaining unit, where applicable, to discuss the findings and recommendations for implementation of the WSLPIP.

Date of Opening Conference: ___ / ___ / _____

Number of people in attendance: _____

Who attended the Opening Conference? Describe their responsibilities in monitoring the Program.

Date of Closing Conference: ___ / ___ / _____

Number of people in attendance: _____

Who attended the Closing Conference? Describe their responsibilities in monitoring the Program.

Section J: Review of Company Records

What records did you review to determine the status of the employer WSLPIP?

Provide an analysis of the historical loss and claim data for this employer for the purpose of exposing trends in claims and losses and identifying specific areas of risk.

Section K: Specialist Information

Name: _____ Company: _____

Address: _____

City: _____ State: _____ Zip code: _____

Certification number: _____ Date of expiration: ____ / ____ / _____

Total number of hours for Evaluation (and report writing): _____ Phone number: (_____) _____ - _____

The Specialist certifies that the information contained in this report is accurate and true and that the incentive program implemented as indicated in this report meets the requirements of the Workplace Safety and Loss Prevention Incentive Program as required by ICR 60.

Signature: _____ Date: ____ / ____ / _____

☐ By checking this box, you indicate that you fully understand the responsibilities associated with providing your signature as a Certified Specialist.

Send this report to the employer. The employer must submit this report to the New York State Department of Labor along with the employer's application for the specific WSLPIP credit. Send applications for the Incentive and Evaluation reports to:

New York State Department of Labor
Workplace Safety and Loss Prevention Program
1220 Washington Ave., Building 12, Room 167
Albany, NY 12226
https://dol.ny.gov/workplace-safety-loss-prevention

Send questions regarding the application process and the procedures for Evaluations under the requirements of Industrial Code Rule 60 to WSLPIP@labor.ny.gov.