Approved:

City of Riverside, California
Human Resources Policy and Procedure Manual

City of Arts &.Innovation

Human Resources Director

City Manager

umber: VI-0.4 Effective Date:

SUBJECT: REASONABLE ACCOMMODATION FOR EMPLOYEES WHO HAVE BEEN INJURED ON THE JOB

PURPOSE:

To establish uniform guidelines for the timely response and handling of reasonable accommodation efforts for employees who have sustained job-related injuries with permanent work restrictions, and who are in need of accommodations to perform the essential functions of their regular duties, or to return to modified or alternative work, in accordance with the Riverside Municipal Code, the California State Labor Code, the Americans with Disabilities Act (the "ADA") and the disability provisions of the California Fair Employment Housing Act ("FEHA"), and other applicable law. [1]

POLICY:

1. **Basic Obligation**

The City of Riverside continues to uphold its commitment of nondiscrimination in its employment practices by ensuring that qualified individuals with disabilities have equal access to employment opportunities available to non-disabled qualified individuals. As part of this effort, the City is obligated to make reasonable accommodation(s) for the known disabilities of employees and will make every attempt to provide reasonable accommodation(s) for its employees who suffer from work related illness or injury precluding performance of the essential functions of regular work.

Reasonable accommodation(s) include any change or adjustment to a job or work environment that permits a qualified injured employee with a disability to participate in the job, to perform the essential functions of a job, or to enjoy benefits and privileges of employment equal to those enjoyed by employees without disabilities. The essential functions shall be those basic job duties that an employee must be able to perform, with or without an accommodation, that are essential in performance of a particular task or the

[1] *These legal provisions will prevail should any aspect of this policy be in conflict. It is further noted and clarified that Human Resources Policy 111-7 addresses reasonable accommodation for applicants and employees who are disabled as a result of a non-industrial related injury or illness.*

reason the position exists.

It is the intent of this policy to employ the provisions of the Riverside Municipal Code Section 2.36.050 of Chapter 2.36, which states, in part: *"All appointments and promotions in the classified service shall be based on merit except those necessary to place City employees who are scheduled for placement into another classification as* a *result of physical inability to perform the employee's current job as* a *result of industrial injury".*

2. Eligibility

Any and all employees who have incurred an illness or injury on the job and have permanent work restrictions resulting from a physical or mental impairment that limits or substantially limits a major life activity and has a record or history of the disability which is known to the City, or regarded or treated by the City as a disability shall be considered for reasonable accommodation(s).

At such time as the City has notice or knowledge that the employee is unable to perform the essential functions of his/her regular position or where an employee requests an accommodation, the City will engage in a timely and good faith interactive process with the employee to evaluate whether or not the employee can be accommodated in a regular, modified, or in an alternative position.

The City will rely on the treating physician's report in determining if the employee meets the definition of medical eligibility, established permanent work restrictions, and has reached the point of "permanent and stationary" or "Maximum Medical Improvement (MMI)". In these cases, as determined by the physician, the employee's condition has reached a plateau and cannot reasonably be expected to either improve or worsen, and the condition or state of the employee is well stabilized and unlikely to change substantially in the next year, with or without medical treatment where further recovery or deterioration is not anticipated.

3. Authority/Responsibility

The Human Resources Department Workers' Compensation Division shall administer and coordinate this program. Injured employees who are involved in this process shall continue to be assigned to, and assisted by the designated Claims Administrator assigned to the handling of the employee's workers' compensation claim.

It is the responsibility of the employee to maintain frequent contact with the Human Resources Department and to make their selves available at all times to participate in the process, including maintaining an active role in the job search and placement process.

The State of California Workers' Compensation Appeals Board has the exclusive jurisdiction (and/or the City's Human Resources Department Workers' Compensation Division subject only to review) regarding the eligibility for, or the provision of supplemental job displacement benefits and all disputed matters regarding these services/benefits must be decided in that forum. The provisions of this policy are not subject to any of the City's grievance procedures.

As it is the City's primary objective to retain injured employees, it shall be the responsibility of all departments to make a good faith effort to accommodate injured employees within their own departments.

4. Interactive Process

The Human Resources Department Workers' Compensation Division shall facilitate the interactive process in collaboration with the relevant department at the time in which the employee's injuries are deemed permanent and stationary by the treating physician and/or at the time the employee is returned to work by the treating physician with permanent work restrictions.

The interactive process is a discussion which can include in person or virtual meeting(s) with the employee to engage in dialogue and discuss the employee's need for potential reasonable accommodation. The City may utilize the services of an outside facilitator for this process. In the following order, and in a timely manner, the Human Resources Department will jointly coordinate a meeting/s with the employee to:

a) Permanently modify the employee's current duties or workstation to accommodate permanent medical restrictions.
b) Transfer the employee into a vacant alternate position for which the employee may qualify and which meets their medical restrictions.
c) Transfer the employee into a vacant alternate position, which can be modified to accommodate the employee's permanent medical restrictions.
d) Evaluate non-vacant, current authorized positions, which the department has available, or anticipates having available, for which the employee meets the qualifications, and make a decision about placement in such position.
e) Identify a position within the department to which the employee could transfer, with the assistance of vocational retraining (which could be on-the-job training, off-the-job training, or a combination of both).

Upon identifying a suitable alternate position, the Human Resources Department shall send written notice to the employee explaining the job offer, job duties, and salary, etc. If the identified position requires a temporary double-fill, double funding, a request for approval shall be submitted to the City Manager. Every attempt shall be made to identify available positions and to conclude the process with formal written notice to the employee within sixty (60) days from notice or knowledge of the permanent and stationary status. The employee shall notify the City within thirty (30) calendar days, following written notification, if they wish to accept the new position.

All job offers made to accommodate employees shall be subject to successfully passing the City's standard pre-placement physical examination for the position. It is understood that there is no requirement to promote an individual or to create a new position to comply with the Riverside Municipal Code, ADA, FEHA or the Labor Code.

Every attempt will be made to accommodate employees with a temporary light duty work assignment during the reasonable accommodation process. Upon medical determination

that the employee's condition is likely to be permanent, the temporary accommodation will continue to be provided until such time as an accommodation is found, but no more than sixty (60) days from knowledge/notice. Thereafter the City will not be obligated to provide continued temporary light duty.

All employees placed into modified/alternative jobs within the City of Riverside under this policy shall be held to the same rules and regulations regarding job performance, retention, promotion and future transfer as all other city employees and will be required to meet the normal probationary period required for the class of position to which they are assigned.

It shall be determined that the City has met its obligation for providing the Interactive Process if a regular position, meeting the necessary requirements, has been identified and offered, in writing, to the employee. If the employee rejects said offer of employment, the employee shall not be entitled to any further supplemental job displacement benefits.

There shall be no liability for the provision of supplemental job displacement benefits to an employee by the City of Riverside if an offer is made of a permanent modified/alternate job which meets the following criteria:

a) The employee has the ability to perform the essential functions of the job.
b) The job is in a regular position projected to last at least 12 months.
c) The job offer provides wages and compensation that are within 15% of those paid to the employee at the time of injury.
d) The job is located within reasonable commuting distance of the employee's residence at the time of injury.

5. No Accommodation Found - Eligibility for Supplemental Job Displacement Voucher

The Human Resource Department shall submit a written status report to the City Manager's Office outlining the process followed and options considered to ensure consideration has been given to all reasonable alternatives for placement, in those cases where City placement or accommodation is not possible.

If it is determined that no permanent accommodation can be made within sixty (60) days of notice or knowledge of a permanent disability (Permanent and Stationary), notice shall be sent to the employee by the Human Resources Department/Workers' Compensation Division informing of inability to reasonably accommodate. Human Resources shall assist the employee in all aspects of making a smooth transition out of City employment.

The following will be discussed and/or decided upon during the meeting:

a) Retirement Options
b) Resignation forms
c) Benefits: Health Insurance (COBRA), Unemployment Compensation, Disability Insurance, Vacation Payoff, Sick Leave Payoff, etc.
d) Selection of a retirement/resignation date

The Human Resources Department will have administrative authority to update any attached forms to this policy on an as-needed basis.

Attachments:

1. Notice of Offer of Modified or Alternative Work Form
2. Notice of Offer of Regular Work Form

State of California
Division of Workers' Compensation
Retraining and Return to Work Unit

NOTICE OF OFFER OF MODIFIED OR ALTERNATIVE WORK

For injuries occurring on or after 1/1/04

owe -AD 10133.53

THIS SECTION COMPLETED BY CLAIMS ADMINISTRATOR (All information in this section must be completed):

Claims Administrator Type: (Please Choose One)

☐ Insurance Company ☐ Third Party Administrator ☐ Employer

_____

Employer (name of firm)

is offering you _____

(Employee name)

the position of a _____

Name of Job

You may contact _____

concerning this offer. Phone No.:_____ Date of offer: _____ Date job starts: _ _ _ _ _ _

MM/DDIYYYY MM/DD/YYYY

_____

Claims Administrator

_____

Claim Number:

NOTICE TO EMPLOYEE (All information in this section must be completed)

Name of employee:

_____ _____

First Name Last Name

(Choose only one)

☐ a specific injury on _____

MM/DD/YYYY

☐ a cumulative trauma inJury which began on _____ and ended on_____

(START DATE MM/DD/YYYY) (END DATE. MM/DD/YYYY)

Date offer received:_____ Date of Birth: _____

MM/DD/YYYY MM/DD/YYYY

You have 30 calendar days from receipt to accept or reject the attached offer of modified or alternative work. Regardless of whether you accept or reject this offer, the remainder of your permanent disability payments may be decreased by 15%. However, if you fail to respond in 30 days or reject this job offer, you will not be entitled to the supplemental job displacement benefit unless:

Modified Work ☐ or Alternative Work ☐

A. You cannot perform the essential functions of the job; or
8. The job is not a regular position lasting at least 12 months; or
C. Wages and compensation offered are less than 85% paid at the time of injury; or D. The job is

beyond a reasonable commuting distance from residence at time of injury.

POSITION REQUIREMENTS (All Information In this section must be completed)

Actual job title _____

Wages. $ _____ Per hour ☐ Week ☐ Month ☐

Is salary of modified/alternative work the same as pre-injury job? Yes ☐ No ☐

Is salary of modified/alternative work at least 85% of pre-injury job? Yes ☐ No ☐

Will job last at least 12 months? Yes ☐ No ☐

Is the job a regular position required by the employer's business? Yes ☐ No ☐

Work location: _____

Duties required of the position:

Description of activities to be performed (if not stated in job description):

Physical requirements for performing work activities (include modifications to usual and customary job):

Name of doctor who approved job restrictions (optional):

Date of report: _____
MM/DD/YYYY

Date of last payment of Temporary Total Disability: _____
MM/DD/YYYY

Preparer's Name _____

Preparer's Signature _____

Date: _____
MMIDD/YYYY

THIS SECTION TO BE COMPLETED BY EMPLOYEE (All information in this section must be completed)

☐ I accept this offer of Modified or Alternative work.

☐ I reject this offer of Modified or Alternative work and understand that I am not entitled to the Supplemental Job Displacement Benefit.

I understand that if I voluntarily quit prior to working in this position for 12 months, I may not be entitled to the Supplemental Job Displacement Benefit.

Signature: _____ Date: _____
MMIDDIYYYY

I feel I cannot accept this offer because:

NOTICE TO THE PARTIES

f the offer is not accepted or rejected within 30 days of the offer, the offer is deemed to be rejected by the mployee.

he employer or claims administrator must forward a completed copy of this agreement to the Administrative Director Nithin 30 days of acceptance or rejection. (Retraining and Return to Work, Division of Workers' Compensation, P.O. Box 20603, S.F., CA 94142-0603)

fa dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to esolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director.

State of California
Division of Workers' Compensation
Retraining and Return to Work Unit

NOTICE OF OFFER OF REGULAR WORK
For injuries occurring on or after 1/1/05
owe - AD 1011s

THIS SECTION TO BE COMPLETED BY EMPLOYER OR CLAIMS ADMINISTRATOR (All information In this section must be completed):

Claims Administrator Type

01nsurance Company D Third Party Administrator ☐ Employer

Case Number _____

Claim Number _____

Claims Administrator _____
{Name of Claims Administrator)

_____ _____
Injured Employee First Name MI

_____ _____
Injured Employee Last Name Date of Birth: MM/DD/YYYY

Based on the opinion of: D Treating Physician ☐ QME ☐ AME

_____
(Name of Physician)

you are able to return to your usual occupation or the position you held at the time of your injury on

(Choose only one)

D a specific injury on _____
MM/DDNYYY

D a cumulative trauma injury which began on _____ and ended on _____
(START DATE MM/0D/YYYY) {END DATE MM/DD/YYYY)

Date you are eligible to return to your job _____ {as stated in the above physician's report) ,
MM/0D/YYYY

Employer _____
(Name of Firm)

Job Title ..... Starting Date _____
MM/DDNYYY

_L

D This **position Is at the same location** and **shift as** your pre-injury **poStion.**

D This position is at a different location than your pre-injury position. The location is:

_____

D This position is for a different shift than your pre-injury position. The shift time is _____ _____
(Start Time) (End Time)

You may contact _____ al _____ concerning this position.
(Name of contact person) Phone Number

You must return the completed form to the employer or claims administrator listed here:

Claims Administrator (To Be Completed By The Employer or Claims Administrator) (All information In this section must be completed)

_____
Name

_____
Claims Malling Address/PO Box (Please leave blank spaces between numbers, names or words)

_____ _____ _____
City State Zip Code

_____ _____
Claims Representative Phone

This position provides wages and compensation of $ _____,that are equivalent to or more than
Weekly Wages

the wages and compensation paid to you at the time of your injury.

This position is expected to last for a total of at least 12 months of work. If this position does not last for a total of at least 12 months of work, you may be entitled to an increase in your permanent disability benefit payments.

I•----------,---::-=-.....,.....,,,.....,.....,...,-,--,-.....,.....----------
(Name of Claims Administrator)
have obtained the above job offer information from your employer.

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

I

Case Number 7

The employee must accept, reject, or object to this offer for regular work and return this form to the employer or claims administrator listed on the form within 20 calendar days of receipt of the offer or it will be deemed that the employee accepted the offer and has waived the right to object to the location or shift.

If the job offered is at a different location than the job you held at the time of your injury, and you believe the commuting distance to this job from the residence where you lived at the time of your injury is not reasonable, you may object to the job offer as not being within a reasonable commuting distance.

You may also waive this commuting distance requirement. You will be considered to have waived this requirement if you accept the above offer of work or do not reject the offer within twenty calendar days of receipt of this notice. The employee should keep a copy of this form for his or her records.

First Name MI

Last Name

Claim Number

Date Offer Received MM/OO/YYYY

I understand that if my disability is permanent and stationary and the employer has fulfilled its legal obligations related to this offer, my remaining permanent disability payments will be decreased by 15% whether I accept or reject this offer.

Offer of Regular Work at Same Location and/or Shift

D I accept this offer of regular work.

D I reject this offer of work. Reason ?

J

THIS SECTION TO BE COMPLETED BY EMPLOYEE:

Offer of Re ular Work at a Different Location and/or Shift

I understand that I have the right to object to a work offer when the location or shift is different than what I had at the time of my injury.

☐ I accept the offer and waive my right to object to the job location or shift as not being within a reasonable commuting distance from the residence where I lived at the time of my injury.

☐ I reject this offer of work. Reason ----------

D I object to this offer because the job location that has been offered is different than the job location I held at the time of my Injury, and I do not believe this job allows a reasonable commute from my residence. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

D I object to this offer because the job shift that has been offered is different than the job shift I held at the time of my injury. I understand if the claims administrator does not agree with this objection, my remaining permanent disability weekly benefit payment may be decreased by 15%.

If a dispute occurs regarding the above offer or agreement, either party may request the Administrative Director to resolve the dispute by filing a Request for Dispute Resolution (Form DWC-AD 10133.55) with the Administrative Director.

_____ Date _____

(Signature) MM/DD/YYYY

Proof of Service By Mail or Hand Delivery

I am a resident of the County of _____. I am over the age of eighteen years and not a party to the within matter. My business address is:

_____

On _____.I served the Notice of Offer of Regular Work on the party/parties listed below by either method of service described below:

A. Placing a true copy of the **Notice of Offer of Regular Work** in a sealed envelope with postage fully prepaid addressed to each person whose name and address is given below by depositing the envelope in the United States mail.

Or

8. Personally serving a true copy of the Notice of Offer of Regular Work on each person whose name and address is given below.

Enter the name of the party and indicate the type of service in the box (either A or B as described above.)

Name of Party:	Type of Service
_____	☐
_____	☐
_____	☐
_____	☐

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed at

_____ on _____

Signature:_____