SCHOOL DISTRICT OF
FORT • ATKINSON

BUSINESS SERVICES
201 PARK STREET
FORT ATKINSON, WI 53538
P: 920.563.7800
F: 920.563.7809
WWW.FORTSCHOOLS.ORG

WORKERS COMPENSATION PACKET

BUILDING/DEPARTMENT ADMINISTRATOR OR SECRETARY:
Attached you will find the following items as listed in the order below. The list below also outlines who each item is intended for and what the intended use is. Please feel free to contact Kay Retzleff in the Business Office (ext. 7800) with any questions you may have.

ITEM — **INTENDED PARTY**

1. **Workers Compensation Flow Chart** — **Building/Department Administrator or Secretary**
   This flow chart is to outline the process to be followed from the point of an injury or near miss all the way through the employee returning back to their full duty without any modifications. This flow chart can be shared with anyone as it is meant to be an informative diagram so everyone is on the same page throughout the process.

2. **Employee Incident Report Form** — **Injured Employee**
   The form is to be completed by the employee and submitted to their immediate supervisor for review and signature. The immediate supervisor must then submit the signed form to Kay Retzleff in the Business Office (Jason Demerath if Kay is not available) *on the same day as the incident*. It is imperative that this form be completed and sent to the Business Office on the same day as state law mandates that workplace accidents be reported to the insurance company within 2 days of the incident occurring. If the employee is incapacitated by the injury and not able to complete the form, the employee's immediate supervisor must complete the form to the best of their ability and immediately report the incident to the Business Office.

3. **Express Scripts Form** — **Building/Department Administrator & Injured Employee**
   The second section of this form is to be completed by the injured employee's immediate supervisor on the same day as the incident and given to the injured employee in case an expedited prescription is needed. The injured employee would then give this completed form to any approved pharmacy to expedite the processing of approved workers compensation prescriptions.

4. **Supervisor Investigation of Incident Form** — **Building/Department Administrator**
   This form is to be completed by the injured employee's immediate supervisor on the same day as the incident and submitted to Kay Retzleff in the Business Office.

5. **Medical Cover Letter** — **Attending Physician**
   This letter is to be sent with the injured employee when they seek treatment for their injury and given to the medical provider.

6. **Fax Cover Sheet** — **Attending Physician**
   This fax cover sheet is to be sent with the injured employee when they seek treatment for their injury and given to the medical provider.

7. **Return to Work Recommendation Form** — **Attending Physician**
   This form is to be sent with the injured employee when they seek treatment for their injury and given to the medical provider.

8. **Return to Work Program & Verifications** — **Injured Employee**
   This form is to be given to the injured employee and they need to complete it and follow up with Kay Retzleff in the Business Office after seeing a physician. It outlines for all involved the physician's restrictions so proper light duty can be assigned.

SCHOOL DISTRICT OF FORT•ATKINSON

WORKERS COMPENSATION FLOW CHART

INCIDENT OCCURS!
Is it life threatening or requires immediate medical attention?

NEAR MISS INCIDENT

YES

NO

CALL 911. NOTIFY SUPERVISOR. ACTIVATE EMERGENCY RESPONSE TEAMS/PROCEDURES

EMPLOYEE completes **INCIDENT REPORT FORM** BEFORE THEY LEAVE FOR THE DAY

SUPERVISOR submits INCIDENT REPORT FORM to **KAY RETZLEFF*** within **24** hours

SUPERVISOR to report injury immediately to **KAY RETZLEFF***, 920.563.7800

Does the **EMPLOYEE** want to have treatment?

YES

NO

SUPERVISOR submits **INCIDENT REPORT FORM** to **KAY RETZLEFF*** within **24** hours

SUPERVISOR completes **INVESTIGATION REPORT**, submits to **KAY RETZLEFF*** as soon as possible and takes corrective action.

Kay Retzleff* Notifies Insurance. No further action needed unless employee seeks treatment later.

Kay Retzleff compiles data for **SAFETY COMMITTEE** review and action.
-
OSHA 300 LOG completed per practice.

Return to Work - Full Duty, No Modifications

MEDICAL TREATMENT

SUPERVISOR provides employee with SDFA WORKERS' COMPENSATION CLAIM REPORTING KIT.

1. **EMPLOYEE** Responsibilities:
   a. Complete **INCIDENT REPORT FORM,** return to supervisor.
   b. Doctor to complete attending **RETURN TO WORK RECOMMENDATION FORM.**
   c. Report availability to work, SDFA to determine modified duty based on physician's report.
2. **MEDICAL PROVIDER**
   a. Review **JOB DESCRIPTION & POSITION ANALYSIS**. Complete attending physician's **RETURN TO WORK RECOMMENDATION FORM.**

(OPTION) EMPLOYEE seeks treatment post incident.

Is Modified Duty needed?

YES

No

Modified Duty offered. Conduct Case Management until RTW Full Duty.

*If Kay Retzleff is not available, please submit to Jason Demerath

07/24/2013

SCHOOL DISTRICT OF
FORT • ATKINSON

EMPLOYEE INCIDENT REPORT FORM

Report any incident that resulted or could have resulted in you being injured at work immediately (same day as incident) to your supervisor or designee. This information will be used to complete several required reports.

CHECK ONE (see reverse side for explanations): ☐ INJURY ☐ ERGONOMIC ☐ ALLERGY/SENSITIVITY ☐ NEAR MISS ☐ OTHER

EMPLOYEE INVOLVED (LAST, FIRST, M.I.)	DATE OF BIRTH	DATE OF HIRE	DATE OF INCIDENT	EXACT TIME OF INCIDENT	LOCATION OF INCIDENT

EMPLOYEE HOME ADDRESS (Street Address, City, State, Zip)		☐ MALE ☐ FEMALE	WORK PHONE	JOB TITLE	WORK HOURS
EMPLOYEE HOME PHONE NUMBER (with area code)	SOCIAL SECURITY NUMBER				

INDICATE THE NAME AND TITLE OF THE INDIVIDUAL TO WHICH YOU REPORTED THE INJURY	DATE INJURY WAS REPORTED

DESCRIBE IN DETAIL WHAT HAPPENED, DESCRIPTION AND CONDITION OF MATERIAL OR EQUIPMENT INVOLVED, WITNESSES (IF ANY), FACTS – NOT OPINIONS
Continue on reverse side if necessary.

BODY PART INJURED (Be Specific):

TOE: _____ (which one) FOOT: ___RIGHT ___LEFT

ANKLE: ___RIGHT ___LEFT LEG: ___RIGHT ___LEFT

KNEE: ___RIGHT ___LEFT THIGH: ___RIGHT ___LEFT

ABDOMEN: ____ CHEST: ____

BACK: ____ NECK: ____

HEAD: ____ NOSE: ____

TEETH: ____ EAR: ___RIGHT ___LEFT

EYE: ___RIGHT ___LEFT ARM: ___RIGHT ___LEFT

WRIST: ___RIGHT ___LEFT HAND: ___RIGHT ___LEFT

THUMB: ___RIGHT ___LEFT FINGER: _____ (which one)

OTHER:

INJURY DESCRIPTION (State exactly the nature of any injury or illness)

YOUR OPINION OR SUGGESTIONS TO AVOID RECURRENCE

MEDICAL TREATMENT INFORMATION

(WORKERS COMPENSATION CLAIM REPORTING KIT RECEIVED ☐)

WILL YOU SEEK MEDICAL TREATMENT? ☐ YES ☐ NO ☐ UNKNOWN AT THIS TIME

PHYSICIAN'S NAME	PHYSICIAN'S CLINIC
PHYSICIAN'S ADDRESS	PHYSICIAN'S PHONE

To my knowledge I herby certify that the above is true and correct. I consent to the release of all medical records that relate to this incident report.

EMPLOYEE SIGNATURE: _____ DATE: _____

SUBMIT THIS FORM TO YOUR IMMEDIATE SUPERVISOR (OR DESIGNEE) **THE SAME DAY AS THE INCIDENT**

SUPERVISOR SIGNATURE: _____ DATE: _____

SUBMIT THIS FORM TO KAY RETZLEFF (KRETZLEFF@FORTSCHOOLS.ORG) **THE SAME DAY AS THE INCIDENT**

FORM ID: Incident Report

EXPLANATIONS FOR TYPE OF REPORT

- **INJURY** – Check this box if an actual physical wound (cut, scrape, broken arm, etc.) has occurred to the employee.

- **ERGONOMIC** – An ergonomic injury is one that is caused as a result of an improper 'fit' of an employee with their working environment/equipment. An example of this would be back pain as a result of an unsupportive desk chair.

- **ALLERGY/SENSITIVITY** – Check this box if the employee experienced an allergic reaction or has noticed a heightened sensitivity to a certain environmental influence. An example of this would be if a custodian broke out in a rash as a result of a certain chemical touching the skin.

- **NEAR MISS** – Check this box if no physical/ergonomic injury or allergic reaction actually occurred, but rather if a dangerous situation has been encountered that could pose a threat of an injury to an employee of the District. This will allow the proper precautionary steps to be taken to resolve the situation and prevent a possible future injury. It will also allow the District to gather data on the areas of highest risk even if an injury or accident has not yet occurred**.**

- **OTHER** – Check this box if none of the other four categories applies.

SFM
The Work Comp Experts®

EXPRESS SCRIPTS®

Workers' Compensation Temporary Prescription Services ID
Important Information

ATTENTION: **INJURED WORKER**

This Workers' Compensation Temporary Prescription Services ID form MUST BE PRESENTED to your pharmacist when you fill your initial prescription(s). If you have questions or need to locate a participating pharmacy, please contact Express Scripts Customer Service at 1-877-568-5522.

ATENCIÓN: TRABAJADOR LESIONADO

Este formulario de Identificación para Servicios Temporales de Prescripción de Recetas por Compensación del Trabajador DEBERÁ SER PRESENTADO a su farmacéutico al surtir su(s) receta(s) inicial(es). Si tiene cualquier duda o necesita localizar una farmacia participante, por favor contacte al área de Atención a Clientes de Express Scripts, en el teléfono 1-877-568-5522.

NOTE: Due to regulations concerning liability, do not issue this Temporary Prescription Services ID form to employer locations/ employees located in the following state: Ohio. The injured employee will receive a permanent prescription card and pharmacy benefit packet from Express Scripts, Inc. once the claim is deemed compensable by SFM Mutual Insurance Company.

Attention Supervisor:
9 digit ID number, pre-printed group number and date of birth must be completed.

ID # _ _ _ /_ _ /_ _ _ _
Social Security Number

DATE OF INJURY _ _/_ _/_ _ _ _
MM/DD/ CCYY

GROUP # **TFUNDMN**

EMPLOYEE DATE OF BIRTH _ _/_ _/_ _ _ _

EMPLOYEE NAME

FIRST **MI** **LAST**

MAILING ADDRESS STREET

CITY **STATE** **ZIP**

EMPLOYER'S NAME

DIVISION OR DEPARTMENT

Help Desk: This is a POS program through Express Scripts only.
For assistance call the Express Scripts Help Desk at 1-877-568-5522

Attention Pharmacist:

SFM's prescription program is administered by Express Scripts. The following are the steps necessary to submit a prescription for the work-related injury.

Please follow the action steps listed below to enter the claim. Be sure you are using NCPDP version 3.2 allowing for faster service.

Step 1	Enter Bin Number 003858
Step 2	Enter Processor Control A4
Step 3	Enter the Group Number as it appears above
Step 4	Enter the injured worker's 9 digit ID (SSN)
Step 5	Enter first name & last name
Step 6	Enter the injured worker's date of injury in the PA field in the format CCYYMMDD

NEED ASSISTANCE? **Pharmacist**, if you have any questions while processing the claim, please call the Express Scripts Help Desk at **1-877-568-5522.**

SCHOOL DISTRICT OF FORT•ATKINSON

SUPERVISOR INVESTIGATION OF INCIDENT

*Supervisor or designee: Complete your investigation **the same day as the incident** and deliver to Business Services, Kay Retzleff.*

EMPLOYEE INVOLVED (LAST, FIRST, M.I.)	JOB TITLE	DATE OF INCIDENT	EXACT TIME OF INCIDENT	LOCATION OF INCIDENT

DATE INCIDENT REPORTED	INTERVIEWED INJURED EMPLOYEE ☐ YES ☐ NO	INTERVIEWED BY	DATE OF INTERVIEW

EXAMINED ACCIDENT SCENE ☐ YES ☐ NO	EXAMINED BY	DATE OF EXAMINATION

WITNESS INTERVIEWED	INTERVIEWED BY	DATE OF INTERVIEW

WITNESS INTERVIEWED	INTERVIEWED BY	DATE OF INTERVIEW

WITNESS INTERVIEWED	INTERVIEWED BY	DATE OF INTERVIEW

WHAT HAPPENED TO CAUSE THIS INJURY OR ILLNESS? Describe employee's activities when injury or illness occurred with details of how event or exposure occurred (include name(s) of other individuals involved, tools, machinery, objects, vapors, chemicals, radiation, unnatural motions of employee, etc.). Also, specify the item(s) which directly injured the employee and caused the accident or disease. Continue on reverse side if necessary.

WHAT SHOULD BE DONE TO PREVENT RECURRENCE (Your opinion please)

WHAT HAVE YOU DONE THUS FAR TO PREVENT RECURRENCE	DATE OF CORRECTIVE ACTION

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING "YES" OR "NO"; INDICATE "N/A" IF THE QUESTION DOES NOT APPLY. PROVIDE AN EXPLANATION ON THE REVERSE SIDE OF THIS FORM IF YOU CIRCLE AN ANSWER THAT IS STARRED (*):

1. WAS THE INJURED EMPLOYEE PROPERLY INSTRUCTED IN SAFE AND EFFICIENT METHODS?	YES	NO*	N/A
2. DID THE EMPLOYEE VIOLATE ANY INSTRUCTIONS, POLICIES OR PROCEDURES?	YES*	NO	N/A
3. WAS THE NECESSARY PROTECTIVE EQUIPMENT WORN? (GOGGLES, SAFETY HARNESS, HARD HAT, ETC.)	YES	NO*	N/A
4. DID ENVIRONMENTAL CONDITIONS CONTRIBUTE TO THE ACCIDENT? (WET FLOOR, POOR SNOW REMOVAL, ETC.)	YES*	NO	N/A
5. WAS THE ACCIDENT CAUSED BY SOMETHING WHICH NEEDED REPAIR?	YES*	NO	N/A
6. WAS THE ACCIDENT CAUSED BY AN UNSAFE ACT OR BEHAVIOR?	YES*	NO	N/A

DID INJURY OCCUR IN COURSE OF WORKER'S EMPLOYMENT? ☐ YES ☐ NO

DID INJURY CAUSE THE EMPLOYEE TO LOSE TIME FROM WORK? ☐ YES ☐ NO ☐ NOT AT THIS TIME

IF YES, LAST DAY WORKED: _____ DATE RETURNED TO WORK: _____ ESTIMATED RETURN DATE: _____

PERSON MAKING THIS REPORT

NAME	TITLE	DATE

BUILDING / DEPARTMENT	PRINCIPAL / SUPERVISOR'S PHONE

PRINCIPAL / SUPERVISOR SIGNATURE: _____ DATE: _____

SUBMIT THIS FORM TO KAY RETZLEFF (KRETZLEFF@FORTSCHOOLS.ORG) **THE SAME DAY AS THE INCIDENT**

(PLEASE ATTACH PHYSICIAN'S RETURN TO WORK REPORT IF AVAILABLE)

SAFETY COMMITTEE REVIEW

FORM ID: Incident Investigation

PROVIDE AN EXPLANATION OF YOUR FINDINGS HERE IF YOU CIRCLED ONE OF THE FOLLOWING ANSWERS THAT WAS STARRED (*)

1. WAS THE INJURED EMPLOYEE PROPERLY INSTRUCTED IN SAFE AND EFFICIENT METHODS? – **NO**

2. DID THE EMPLOYEE VIOLATE ANY INSTRUCTIONS, POLICIES OR PROCEDURES? – **YES**

3. WAS THE NECESSARY PROTECTIVE EQUIPMENT WORN? (GOGGLES, SAFETY HARNESS, HARD HAT, ETC.) – **NO**

4. DID ENVIRONMENTAL CONDITIONS CONTRIBUTE TO THE ACCIDENT? (WET FLOOR, POOR SNOW REMOVAL, ETC.) – **YES**

5. WAS THE ACCIDENT CAUSED BY SOMETHING WHICH NEEDED REPAIR? – **YES**

6. WAS THE ACCIDENT CAUSED BY AN UNSAFE ACT OR BEHAVIOR? – **YES**

SCHOOL DISTRICT OF FORT • ATKINSON

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MEDICAL COVER LETTER

MEDICAL PROVIDER:

The School District of Fort Atkinson is committed to preventing workplace injuries, controlling injuries that do occur, and providing alternative duties after an injury. We offer many types of alternative work and/or transitional work, which allow the injured employee to work within their medical restriction.

- Please complete the enclosed medical report to list any applicable medical restrictions.
- Please complete this form and fax a copy to our office using the fax cover page on the back of this letter.
- Please also give a copy of this completed form to the employee.

PLEASE SUBMIT BILLS & CORRESPONDING RECORDS TO OUR INSURANCE COMPANY:

SFM
Policy #WC 57430
PO Box 9416
Minneapolis, MN 55440-9416
Phone: 800-937-1181
Fax: 800-944-1169 or 952-838-2000
www.sfmic.com

EMPLOYER CONTACT:

Kay Retzleff
School District of Fort Atkinson
201 Park Street
Fort Atkinson, WI 53538-2155
Phone: 920-563-7800
Fax: 920-563-7809
Email: kretzleff@fortschools.org

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FACSIMILE TRANSMISSION

To: KAY RETZLEFF

Company: SCHOOL DISTRICT OF FORT ATKINSON

Fax Number: 920.563.7809

Phone Number: 920.563.7800

Re: MEDICAL REPORT FOR WORKERS COMPENSATION CLAIM

From: _____

Phone Number: _____

Date: _____

# of Pages (Including Cover Sheet): _____

Comments: _____

_____

_____

_____

_____

_____

If there is a problem with this transmission, please call the person listed above at 920.563.7800.

WORK ABILITY and RETURN-TO-WORK

Download at sfmic.com ▶

Send this completed form with the employee.

Send itemized medical billings and records to:
CorVel Corporation, MedCheck
3001 NE Broadway Street, Suite 620
Minneapolis, MN 55413

EMPLOYEE	DATE OF BIRTH
EMPLOYER	DATE OF INJURY/ILLNESS

DIAGNOSIS	ICD-9 CODE

History and findings:

Work related injury/illness? ☐ No ☐ Yes ☐ To be determined

Any pre-existing conditions affecting this injury/illness? ☐ No ☐ Yes, description:

Permanent partial disability? ☐ No ☐ Yes,_____%

Maximum Medical Improvement reached? ☐ No ☐ Yes, date reached_____

RETURN TO WORK

☐ Return to work with ***no limitations*** on _____/_____/_____
MO DAY YR

☐ Return to work ***with limitations*** on _____/_____/_____ through _____/_____/_____
MO DAY YR MO DAY YR

_____ **has light-duty work available. Please call** _____ at ( ) _____ **if you plan to take this employee off work.**

☐ Unable to work from _____/_____/_____ through _____/_____/_____
MO DAY YR MO DAY YR

EMPLOYEE'S CAPABILITIES

BODY PART AFFECTED: ☐ Neck ☐ Upper back ☐ Lower back ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Leg ☐ Knee ☐ Ankle ☐ Foot

☐ Other _____

SIDE AFFECTED: ☐ Left ☐ Right ☐ Both

	Not at all	Rare	Occa-sional 0-33%	Fre-quent 34-66%	Contin-uous 67-100%
Lift/Carry					
0-9 lbs	☐	☐	☐	☐	☐
10-19 lbs	☐	☐	☐	☐	☐
20-29 lbs	☐	☐	☐	☐	☐
30-39 lbs	☐	☐	☐	☐	☐
40-49 lbs	☐	☐	☐	☐	☐
No lift from floor	☐	☐	☐	☐	☐
Push/Pull without resistance					
0-19 lbs	☐	☐	☐	☐	☐
20-40 lbs	☐	☐	☐	☐	☐
> 40 lbs	☐	☐	☐	☐	☐
Bend	☐	☐	☐	☐	☐
Twist/turn	☐	☐	☐	☐	☐
Kneel/squat	☐	☐	☐	☐	☐
Sit	☐	☐	☐	☐	☐
Stand/walk	☐	☐	☐	☐	☐
Ladder/stair climb	☐	☐	☐	☐	☐

Hand, wrist and shoulder activities

	Not at all	Rare	Occa-sional 0-33%	Fre-quent 34-66%	Contin-uous 67-100%
Avoid prolonged, repetitive or forceful:					
Gripping/grasping	☐	☐	☐	☐	☐
Repetitive wrist motion	☐	☐	☐	☐	☐
Reaching:					
Above shoulder	☐	☐	☐	☐	☐
At shoulder height	☐	☐	☐	☐	☐
Below shoulder	☐	☐	☐	☐	☐

Restrictions (circle):

Keyboarding (hrs/shift) 0 1-2 3-4 5-6 7

Writing (hrs/shift) 0 1-2 3-4 5-6 7

Total spread out evenly over shift at_____intervals

Change positions every
- ☐ As needed
- ☐ Half hour
- ☐ One hour
- ☐ Two hours

☐ Worksite stretches, i.e., per handout

☐ Exercises ☐ Other_____

Comments

INSTRUCTIONS

☐ Keep wound clean and dry. Change dressing every_____

☐ Medication_____

☐ Ice_____ min._____ ☐ Heat_____ min._____

☐ Splint/brace_____

☐ Referral_____

*Follow-up appointment scheduled for*_____

THIS TREATMENT HAS BEEN DISCUSSED WITH THE EMPLOYEE

HEALTH CARE PROVIDER SIGNATURE	LICENSE / REGIS.#	DATE OF EXAM
HEALTH CARE PROVIDER SIGNATURE		

SCHOOL DISTRICT OF
FORT • ATKINSON

RETURN TO WORK PROGRAM & VERIFICATIONS

EMPLOYEE NAME: _____

RETURN TO WORK COORDINATOR

Kay Retzleff
Business Services
201 Park Street
Fort Atkinson, WI 53538
Phone: 920.563.7800
Fax: 920.563.7809
Email: kretzleff@fortschools.org

EMPLOYEE RESPONSIBILITIES

- ☐ Immediately return a copy of the *Physician's Return to Work Recommendations* to the Return to Work Coordinator
- ☐ Inform Return to Work Coordinator of your normal work hours, days and location

  Normal Work Location(s): _____

  Normal Work Days: Sun Mon Tues Wed Thurs Fri Sat

  Normal Work Hours: _____
- ☐ Immediately return a copy of any future paperwork associated with this claim to the Return to Work Coordinator

CURRENT RESTRICTIONS PER PHYSICIAN'S RETURN TO WORK RECOMMENDATION FORM

EMPLOYEE IS ON RESTRICTED DUTY UNTIL: _____

I hereby acknowledge the above work restrictions as recommended by the attending physician and agree to adhere to these restrictions until the physician has made a change to the above restrictions. I understand that if I do not adhere to these restrictions it may jeopardize my ability to continue to collect my workers compensation benefits.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

Return to Work Coordinator – Please immediately give a copy of the front and back of this sheet to the following individuals. Please also inform these individuals of when the employee is expected to begin performing their duties under these restrictions:

- ☐ Employee's Supervisor
- ☐ Building Secretary
- ☐ Employee

POSSIBLE RETURN TO WORK ASSIGNMENTS

Consideration should not only be given to the work restrictions outlined by the medical provider, but for the employee's abilities as well. Working to achieve a match between an individual's capabilities and appropriate transitional work task is instrumental in creating a successful Return to Work experience. Here is a list of possible duties, not meant to be all inclusive:

Answer phones
Assist in library
Blowing tire chips back into containment areas
Catalog and index books
Check and repair safety equipment
Check children in and out of school
Check homework
Cleaning walls
Collect attendance slips
Conduct safety inspections
Correct papers
Decorate bulletin boards
Dusting coat hooks
Dust library
Ensure visitors sign in and out
Folding lost and found
Greet families and guests
Help coordinate volunteers
Inventory
Monitor hallways, cafeteria, buses
Moving tire chips to keep seems covered
Organize and update files/cabinets
Orient new-hires
Painting
Patrol parking lots
Print and assemble materials, direct mail
Problem solving which clocks need to be replaced and repaired and coordinate their repair
Removing black heel marks off the floor
Send or deliver mail or messages
Serve snacks and meals
Shred outdated, confidential materials/paper
Stock supplies
Supervising/cleaning in the lunchroom
Supervising on the playground
Tutor, assist in classroom, study hall
Update manuals
Wash windows, sinks, bubblers
Working clerical for teachers (cutting, stapling, binding, copying)

The following is a sample of a work day schedule for an employee on restricted duty:

7:30 AM to 8:00 AM – Traffic Safety in Drive Through (As needed after established)
8:00 AM -9:45 AM See List
9:45 to 10:15 AM Supervise Playground
10:15 to 11:10 AM See List
11:10 AM to 11:20 AM Supervise in the Lunchroom
11:20 AM to 12:15 PM Supervise on the Playground
12:15 PM to 12:45 PM See List
12:45 to 1:15 PM Lunch
1:15 PM to 2:00 PM Supervise on the Playground
2:00 PM to 2:45 PM See List
2:45 PM to 3:15 PM Traffic Safety
3:15 PM to 4:00 PM See List