



SYSTEM COUNCIL NO. 6

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS

P. O. Box 648 • Powell, TN 37849 • Office 865-692-3533 • Fax 865-315-7063 • ibewsc6.org

NS-016-22

February 01, 2022

Brothers and Sisters,

In an attempt to help our membership navigate the confusion created by Norfolk Southern's Return-To-Work (RTW) process, I have compiled the various documents into one file that Norfolk Southern Health Services (NSHS) seems to be requiring at this time. Please be advised that the Carrier may change the process at any given time based on their internal departmental changes.

While my office will attempt to update this file as often as possible, the Carrier does not always inform us of any changes in a timely manner. Always check the Carrier's website, nscorp.com, for the latest potential updates to the process. As opposed to word of mouth, local supervision misinformation, or the "call list" based on alphabetical arrangement, the website should have the most current source of instructions.

OF VITAL IMPORTANCE, include the email/phone where you wish to receive communications and instructions from NSHS on the "Attending Physician's Return to Work." Currently, I have found that NSHS will default to a member's corporate email that the member has no access to during a medical leave.

In Your Service,

Tom Owens

General Chairman

Attending Physician's Return to Work Report – Form Instructions

Purpose of the form:

The Attending Physician's Return to Work Report should be completed when an employee is released to return to work from to any of the following:

- Treatment for a significant illness or injury requiring hospitalization or surgical intervention
- Any medical condition that may impact an employee's performance or safety on the job
- Any medical absence of 7 days or more. The information is used to determine Fitness for Duty on returning to work in a safety critical work environment.

Who completes the form:

The **employee completes the top portion of the form in its entirety** to prevent processing delays. The remainder of the form should be completed by each of the employee's treating physicians or other appropriate licensed treating healthcare providers. **The healthcare provider or employee should return the completed form along with any additional treatment information to:**

1. Email: Notifyhealthservices@nscorp.com
2. Fax: 470-463-5081

Contact information:

If you have questions about the Attending Physician's Return to Work Report, you can email Notifyhealthservices@nscorp.com.

Additional Instructions for Certain Diagnoses

If any of the conditions named below apply, please provide the additional information requested along with this report. **Office visit notes are required on each relevant condition, summaries are not sufficient for determination of clearance.**

SURGICAL PROCEDURE

If employee underwent a surgical procedure: provide operative note and last post-operative note.

CARDIAC ISSUE

If employee is suffering from heart disease: submit most recent office visit note, report indicating most recent ejection fraction (echocardiogram, nuclear study, or catheterization report if applicable), recent Bruce protocol stress test report, Holter monitoring report, or results of any other specialized testing that may have been performed in the course of evaluation and treatment (if not already performed, any tests used to determine fitness for duty will be at the employee's expense).

DIABETES

If employee is suffering from diabetes mellitus: a fasting blood sugar and glycosylated hemoglobin (Hgb A1C) performed within the last thirty (30) days; prescribed diet; frequency, nature and severity of any symptomatic hypoglycemic or hyperglycemic episodes or reactions in the past six months; state of employee's compliance with treatment regimen; frequency of employee's visits to you for monitoring and nature of any employee self-monitoring; nature, severity and extent of any diabetic complications (e.g., retinopathy, neuropathy, etc.); ability of employee to recognize and manage hypoglycemic reactions. Submit most recent office visit note.

NEUROLOGICAL ISSUE

If employee is suffering from seizure disorder, stroke/TIA, TBI or disturbance of consciousness: frequency, nature and severity of any seizures, disturbances of consciousness, syncope, or dizziness,

in past one year; results of recent neurological examination; results of any tests (e.g., EEG, brain scan, blood levels of medications, etc.) that may have been performed; state of employee's compliance with treatment regimen; frequency of employee's visits to you for monitoring. Submit most recent office visit note.

SLEEP DISORDER

If employee has been diagnosed with a sleep disorder submit most recent office visit note; copies of applicable test report (sleep study, MSLT, MWT) before and after treatment along with treatment compliance report to verify using device as recommended by treating provider.

ORTHOPEDIC ISSUE

If employee is being treated for an orthopedic condition or injury (conditions related to the neck or back or involving the upper and lower extremities): Submit most recent office visit note specifying physical abilities, strength, ROM, or any physical limitations, copy of 3 most recent physical therapy reports including a discharge summary, and imaging studies (MRI, CT, X-ray) if applicable.

SUBSTANCE ABUSE

If employee is suffering from substance abuse: copy of results of any recent alcohol and/or drug testing; details of rehabilitation and recovery plan; nature, extent and severity of any complications of substance abuse. Employee will also be required to contact the NS Employee Assistance Program.

MENTAL HEALTH DISORDER

If employee has been hospitalized, submit the discharge summary or post discharge outpatient visit report. Submit most recent office visit note.

Attending Physician's Return to Work Report

Form to be completed and submitted when an employee is released to return to work following treatment for: a significant illness or injury requiring hospitalization or surgical intervention, any medical condition that may impact an employee's performance or safety on the job or following any medical absence of 7 days or more. Failure to attach all applicable documentation requested on page 1 of this form will delay your return to work clearance. Summaries of office visit notes are not accepted. **Please print clearly. illegible forms will be returned to the employee.**

Employee Name		DOB	Employee Mobile Number
Address			
Employee Personal Email			
Last 4 SSN	I.D. Number	Occupation/Craft	
Supervisor Name		Supervisor Phone Number	
Department		Work Location	

Last Date Worked: _____

Employee Claims On-Duty Injury: Yes No. If yes, see page 6.

Employee consents to receive information pertaining to the status of their case via text message
(Message and Data rates may apply depending on mobile carrier): **Yes No**

The above employee has reported that he has been under your professional care. To enable his consideration his return to work, please complete the remaining portion of this report in its entirety. For certain diagnoses or conditions specific additional treatment information may be required. See instructions on page 1. Please contact notifyhealthservices@nscorp.com if any clarification regarding job duties or further discussion is desired.

A copy of recent medical records may be submitted in lieu of completion of this form provided all necessary information identified below is included in the medical records.

Please complete this form in its entirety and return all attachments to health services at the email or fax above.

All information will be treated confidentially. Thank you.

1. Chief Complaint / History: _____

2. Current Vitals: BP _____ Ht _____ Wt _____ If treating Diabetes: HgbA1c _____ Fasting BS _____

3. Current Physical Exam Findings: _____

4. Diagnoses with ICD Codes: _____

5. Treatments: (include procedures or surgeries and dates performed) _____

6. Current medications with dosages and frequency: (may attach separate medication list) _____

7. Will any medication employee is taking adversely affect alertness, coordination, judgment, vision, or gait?
Please check one: Yes No
If yes, please explain: _____

8. Date of Next Visit (if any) : _____

9. For the current episode of care what date range or individual dates was the employee unable to work?
From _____ To _____ OR Individual Dates: _____

10. Prognosis: _____

11. The employee is able to perform his/her assignment without posing a direct threat to his/her own safety or the safety of others on (return date should not be more than two weeks in advance of last assessment):
Return to Work Date: _____ Without Restrictions
 With Restrictions

(Whether a person poses a "direct threat" to himself/herself, or others must be based on the most current medical knowledge and/or the best available objective evidence about this individual. There must be a significant risk of substantial harm; the risk may not be speculative or remote. In reaching your conclusion, you should consider the duration of the risk, the nature and severity of the potential harm, the likelihood that the potential harm will occur and the imminence of the potential harm. If you conclude that this person would pose a "direct threat" please provide us with the basis for your conclusion addressing the issues noted above.)

12. Please specify any recommended activity restrictions, limitations, or accommodations: _____

Restrictions are: Permanent Temporary

If temporary, how long will recommended work restrictions be in effect? _____

Signature of Treating Healthcare Provider _____

Date _____

Print Name _____

Specialty _____

Phone & Fax Number _____

Street Address _____

City, State, Zip _____

Information to Submit if Claimed as On-Duty Injury

- If applicable, Emergency room, Urgent Care, or other initial evaluation records
- Initial Office visit notes from all treating health care providers (including any treating specialist) and include most recent one-year OV notes including return to work recommendations.
- If applicable, recommended work restrictions and/or accommodations, and if any, their anticipated duration from any treating health care provider (including any treating orthopedic doctor's)
- Admission note and discharge summary for all hospitalizations
- If applicable, Operative report, if applicable – Either from surgeon's office or hospital where the surgery was performed. It is not necessary to provide all hospital records.
- All diagnostic study reports, such as X-ray, MRI, EMG - please do not send X-ray or MRI films!
- If applicable, Physical therapy initial evaluation and discharge summary along with last three therapy notes, if applicable
- IME, FCE or other similar evaluations, if applicable

NSHS MEDICATION GUIDANCE

FOR EMPLOYEES PERFORMING SAFETY-SENSITIVE DUTIES*

Norfolk Southern’s strong commitment to safety requires that employees be at their best every time they are at work. It is the responsibility of each employee to ensure that they are physically and mentally fit for duty and free from any potential impairment caused by illicit drugs, prescription drugs, alcohol, over-the-counter medications, or supplements. While there are many side effects which can be caused by medications, including over the counter and supplements, the most concerning substances are those which can cause sedation. In general, prescription pain medicines, muscle relaxers and sleep aids have these restrictions. These are only examples. Medication labels should be read carefully and before beginning any medication which includes a warning of “Do not drive or operate heavy machinery until you know how this medication affects you” you should discuss that medication and all other medications you are taking or might take, with your health care provider.

The purpose for this list of restricted medications is to help you with discussions with your treating healthcare provider so you can minimize risk to your safety and the safety of others from medications.

In general, NSHS medication guideline prohibits use of a medication which may impair while at work and for a minimum number of hours prior to reporting for work. The list below is only an example of medications which fall under the following time frames of concern.

Please provide this chart to your prescribing health care provider. Ask if your prescription medication falls within one of the categories described below. If it does, follow the applicable guidance. If you cannot meet these guidelines, promptly contact NSHS for a fitness- for-duty evaluation.

Not Permitted

These medicines are not permitted: Spravato (esketamine), medical or recreational marijuana.

CBD products (must be used with caution as contain THC and will not be a valid explanation for a positive drug test. Contact Health Services if any questions)

24 Hours

The last dose of these medications must be at least 24 hours prior to reporting for safety-sensitive duty and may not be taken while on duty.

Opioid and Synthetic Opioid Drugs *(Not all inclusive; most common medications)*

Generic Name	Brand Examples
Buprenorphine	Buprenex, Butrans, Suboxone, Subutex
Butorphanol	Stadol
Fentanyl.....	Abstral, Actiq, Fentora, Duragesic, Lazanda, Onsolis, Sublimaze
Naltrexone.....	Vivitrol
Methadone.....	Methadone

12 Hours

The last dose of these medications must be at least 12 hours prior to reporting for safety-sensitive duty and may not be taken while on duty.

Opiate and Synthetic Opioid Drugs <i>(Not all inclusive, most common medications)</i>		Benzodiazepines <i>(Not all inclusive, most common medications)</i>	
Generic Name	Brand Names (as example)	Generic Name	Brand Names
Hydrocodone extended release	Hysingla ER, Zohydro ER, Roxicodone, OxyIR	Clorazepate	Tranxene,
Hydromorphone	Dilaudid, Palladone	Diazepam	Valium
Meperidine	Demerol	Midazolam	Versed
Morphine	Avina, Duramorph, Kadian, MS Contin, MSIR, Oramorph, Roxanol	Lorazepam	Ativan
Nalbuphine	Nubian	Temazepam	Restoril

Oxycodone Extended Release	OxyContin, Dazidox, Oxecta, Oxyfast, OxyIR, Percolone, Roxicodone		Triazolam	Halcion
Oxymorphone	Opana		Barbiturates and Others <i>(Not all inclusive, most common medications)</i>	
Pentazocine	Talwin NX		Generic Name	Brand Examples
Tapentadol	Nucynta		Amobarbital	
Tramadol	ConZip, Rybix, Ultram		Butabarbital	
			Butalbital	Esgic, Fioricet, Fiorinal, Phrenilin
			Socobarbital	
			Pentobarbital	
			Pregabalin, Gabapentin	Lyrica, Neurontin
			Carisoprodol	Soma

8 Hours

The medications listed below break down more quickly in your body and can be used up to 8 hours before reporting for safety-sensitive duty and may not be taken while on duty in a safety sensitive position. You are responsible for working with your prescribing health care provider to ensure use of any of these medicines adheres to these restrictions. These are only examples of medications in this group.

Generic Name	Brand Example
Codeine	Tylenol with Codeine, Tylenol #3, Empirin #4
Cyclobenzaprine	Flexeril, Flexepax, Amrix
Dihydrocodeine	Panlor DC, Synalgos DC, Zerlor
Diphenhydramine	Benadryl, Tylenol PM, Robitussin PM, other night-time cold /pain medicine
Hydrocodone	Vicodin, Hysingla, Zohydro, Norco
Oxycodone	Endocet, Endodan, Endocodone, Percocet, Percodan, Roxicet, Tylox
Metaxalone	Skelaxin
Tizanidine	Zanaflex
Methocarbamol	Robaxin, Robaxin 750
Baclofen	Lioresal, Gablofen
Cyclobenzaprine	Flexeril
Zolpidem	Ambien
Eszopiclone	Lunesta
Zaleplon	Sonata

Use of Prescription Stimulants

Prescription stimulants are commonly prescribed for conditions such as Attention Deficit Hyperactivity Disorder (ADHD). These medicines will be identified by urine drug testing, and you will need to verify your prescription during the drug testing process. There is no restriction on their use while at work if accompanied by a valid prescription and used as directed by your health care provider.

If you have questions about any medication use, please email NotifyHealthService@nscorp.com

Frequently Asked Questions About NSHS Medication Guidance

1. **Which NS employees are governed by the medication guidance in the Medication Guidance document?**
This medication guidance applies to all employee in *safety-sensitive positions.
2. **I am prescribed a medication in one of the categories listed on Medication Guidance Document. I meet the NSHS medication guideline. Do I need to contact NSHS for a fitness-for-duty evaluation?** No. You do not need to contact NSHS for a fitness-for-duty evaluation unless you do not meet the medication guidelines and/or you are prescribed a narcotic for treatment of opioid dependence.
3. **I am prescribed a medication in one of the categories listed on Medication Guidance Document. I cannot follow the medication guideline. Will I be removed from work?** Each case is evaluated on an individual basis. A fitness-for-duty assessment will be based on your specific situation. This evaluation typically begins with a request for you to have your health care provider provide NSHS with more information about your medication, medical condition and any recommended work restrictions or accommodations.
 - If you are unable to meet the applicable medication guideline, you may be restricted by an NSHS clinician from performing your safety-related duties pending completion of the fitness-for-duty evaluation.
 - These are guidelines only. It is your responsibility to use good judgment. Do not compromise your safety at work. Do not report to work or remain at work if you feel you are unsafely impaired by your medication.
4. **Does Medication Guidance Document list all prescription medications that may cause unsafe impairment?** No. This form provides you with NSHS prescription medication guidance for two major medication categories. These commonly prescribed medications may cause unsafe impairment at work. This list is not all-inclusive. There are many medication categories and numerous medications not listed that also can cause unsafe impairment. This list is subject to change and will be updated periodically. If the medication label indicates "do not drive or operate heavy machinery" (even if you know how the medication affects you) then it should be considered potentially impairing.
5. **Should I change or stop the prescription medication on my own if I cannot follow NSHS medication guidelines?**
No. Always follow the prescription directly as written. Never stop the medication on your own. Never change the dose or frequency of use unless advised to do so by your prescribing health care provider.
6. **Where can I find more guidance about safe use of medication?** Talk to your prescribing health care provider. Ask your pharmacist. Contact NSHS. Educational resources about medication are also available on www.nscorp.com/medical

Medical information is available at www.nscorp.com/medical.

***Safety-sensitive positions** are as described below as well as yardmasters, crew haulers, pilots, and NS police officers, those requiring commercial motor vehicle medical certification, as well as those in physically demanding position if applicable. A safety-sensitive job offer or employee is any agreement or non-agreement person who: (1) is covered under the hours of service laws; or (2) inspects, installs, constructs, repairs, or maintains track, roadbed, bridges and signal and communication systems; or (3) inspects, repairs, or maintains locomotives, passenger cars or freight cars, or other on-track equipment when such equipment is in service that constitutes a train movement; or (4) determines that an on-track roadway maintenance machine or hi-rail vehicle can be used without repair of a non-complying condition; or (5) directly instructs, mentors, inspects, or tests, as a primary duty, any person while that other person is engaged in a safety-related task; or (6) is responsible for conducting periodic tests and inspections of safety-sensitive employees



UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD
OFFICE OF PROGRAMS
POST OFFICE BOX 10695
CHICAGO, IL 60610-0695

Form Approved
OMB No. 3220-0039

March 27, 2020

Instructions to Claimant

You must have your doctor complete the next page of this form if you wish to claim benefits for days after . If you have recently provided medical evidence beyond this date, please disregard this notice. The Railroad Retirement Board's authority for requesting this statement is 45 U.S.C. 362(i) and 20 CFR 335.3. Be sure to complete and return promptly any sickness benefit claim forms you receive. **Do not give claims to your doctor.**

IMPORTANT NOTICE

Paperwork Reduction Act Notice to Doctor

Additional medical evidence is needed to support further claims for sickness benefits under the Railroad Unemployment Insurance Act (RUIA). This information is to be supplied without expense to the Railroad Retirement Board (RRB). Please complete the items on the next page. The RRB is authorized to collect this information under Section 12(i) of the RUIA. You are not required to furnish this information. If you do not, however, no benefits will be paid to your patient.

We estimate this form takes an average of 8 minutes to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to Associate Chief Information Officer for Policy and Compliance, Railroad Retirement Board, 844 N. Rush Street, Chicago, Illinois 60611-1275.

(Continued On Next Page)

SI-7 (03-17)

SUPPLEMENTAL DOCTOR'S STATEMENT	Social Security Number XXX-XX-										
Patient's Name											
INSTRUCTIONS TO DOCTOR: <i>Please complete all items and return this form</i> in the enclosed envelope to the Railroad Retirement Board (RRB) <i>immediately</i> . No additional sickness benefits can be paid to this patient until this supplemental medical form is completed and returned. This information is to be supplied without expense to the RRB. Also read the "Important Notice" on the previous page of this form.											
1. Have you examined or treated the patient for illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give the date you last examined or treated the patient: _____											
2. Please give: A. Diagnosis: _____ B. Current objective finding: _____ C. Complications (show any factors retarding recovery): _____ D. Current response to treatment: _____											
3. Did the patient require surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No – Go to Item 4 If "Yes" - A. Indicate the type of surgery: _____ B. Date of most recent surgery: _____											
4. If maternity, give estimated or actual date of delivery: _____											
5. Do you believe the patient is now able to work without restriction in his/her last occupation? A. <input type="checkbox"/> Yes – Give the date the patient became able to work: _____ B. <input type="checkbox"/> No – Give an estimated return-to-work date and explain how the medical evidence shows the patient is still disabled. Estimated return-to-work date (<i>if indefinite, give estimated date</i>): _____ Explanation: _____											
6. Has the patient reached maximum medical recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No – Go to Item 7 If "Yes" - A. Give the date the patient reached maximum recovery: _____ B. Is the patient able to do some kind of work? <input type="checkbox"/> Yes <input type="checkbox"/> No											
7. I certify that the information I am giving is true, complete, and correct. I understand that criminal and civil penalties may be imposed on me for false or fraudulent statements or for withholding information to cause or prevent payment of benefits by the RRB.											
Signature of Doctor	Degree/Title										
Name of Doctor (<i>Print or Type</i>)	Date										
Address (<i>Print or Type</i>)	Office Telephone Number (<i>Include area code</i>) ()										
City, State, ZIP Code	National Provider Identifier										
<table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table>											

Re: Disability Letter

We are in receipt of information from your employer indicating that you stopped working because you are disabled. In order for your health coverage to continue, we must have the proof of your disability statement below completed by your attending physician.

Note: If you have become eligible for Medicare, please notify us.

The completed form should be mailed or faxed to Railroad Enrollment Services.
The mailing address and fax number are:

Railroad Enrollment Services
PO Box 30775
Salt Lake City, UT 84130-0775
Fax #: (248) 733-6080

IF THIS PROOF OF DISABILITY IS NOT RECEIVED, YOUR COVERAGE WILL BE TERMINATED.

If you have questions, please call Railroad Enrollment Services at (800) 753-2692.

TO BE COMPLETED BY ATTENDING PHYSICIAN:

Please put SSN here:

I certify that _____ has been disabled from performing his/her regular occupation from _____ (Date) to _____ (Date) due to the following condition(s):

Is the employee permanently disabled from his/her regular occupation? **YES NO**
(Please circle one.)

If no, please give us an estimated return to work date _____, or
the date of his/her next appointment with you _____.

Physician's Signature

Date