**Return to Work Program**

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**Worker Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Worker Name: |  | Claim No: |  |
| Address: |  |
| Telephone (home): |  | Telephone (work/mobile): |  |
| Email: |  |
| Position Title: |  | Section: |  |

**Employer Details**

|  |  |
| --- | --- |
| Employer/Business Name: |  |
| Address: |  |
| Supervisor: |  | Telephone (work/mobile): |  |
| Email: |  |
| Person coordinating return to work program: |  |
| Telephone: |  | Email: |  |

**Insurer Details**

|  |  |
| --- | --- |
| Name of Insurer: |  |
| Address: |  |
| Contact person: |  | Telephone: |  |
| Email: |  |

**Medical Details**

|  |  |
| --- | --- |
| Name of Treating Medical Practitioner: |  |
| Address: |  |
|  |
| Telephone: |  | Facsimile: |  |
| Email: |  |

**Return to Work Program (continued)**

**Program Details**

|  |
| --- |
| Work restrictions on the current certificate of capacity (if any): |
|  |
|  |
|  |
| Date of Review by Treating Medical Practitioner: |  / /  |

|  |
| --- |
| **Return to Work Goal** |
|  | Same Employer / Same Job |   | New Employer / New Job |
|  | Same Employer / Modified Job |   | Other Workplace Rehabilitation1 Options |
|  | Same Employer / New Job |
|  |
| Start Date: / /  | Review Date: / /  |

1For the purposes of this Program the term ‘workplace rehabilitation’ means ‘vocational rehabilitation’ as defined in the *Workers’ Compensation and Injury Management Act 1981.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Week | Date | Hrs of work | Duties | Restrictions |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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| --- |
| **Note:** *These details are only included if the worker, the employer and the treating medical practitioner have agreed to a referral to an approved workplace rehabilitation provider.* |
|  |
| Name of Approved Workplace Rehabilitation Provider: |  |
| Address: |  |
| Telephone: |  | Email: |  |
| Date of Referral: |  / /  |

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|  |
| --- |
| I agree to the content of this Return to Work Program. |
| **Worker’s Signature:** |  | Date: |  / /  |
| **Employer’s Signature:** |  | Date: |  / /  |
| Name of person signing on behalf of employer: |  |
| Position: |  |

**Return to Work Program (continued)**

**Actions to be completed to enable the injured worker to return to work**

|  |  |  |
| --- | --- | --- |
| Action | Person Responsible | Completion/ Review Date |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Workplace Rehabilitation Details**

**Agreement by Parties at the Workplace:**

**Agreement by Parties at the Workplace:**