**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:**