Insurance Commission of Western Australia

Government Insurance Division
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Return to Work Template

Claimant details

Last name:	First name:
Address:	
Phone:	Email:
Position title:	Section:

Employer details

Employer:	
Supervisor name:	
Supervisor phone:	Supervisor email:
Person coordinating return to work program:	
Position:	
Coordinator phone:	Coordinator email:

Insurer details

Insurer managing claim: Insurance Commission of Western Australia	Claim number:
Contact name:	
Contact phone:	Contact email:

Medical details

Worker's treating medical practitioner:	
Address:	
Contact phone:	Contact email:

Return to work goal

☐	Same employer/same job	☐	Same employer/new job
☐	Same employer/modified job	☐	New employer/new job
☐	Other rehabilitation options:		

Program details

Start date:	Review date:

Week	Date	Hours of work	Duties	Restrictions

Work restrictions/special needs (if any):

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

Item No	Action	Person responsible	Completion/ review date

Vocational rehabilitation details

These details are only included if the worker, the employer and the treating medical practitioner have agreed to a referral to a workplace rehabilitation provider.	
Worker's workplace rehabilitation provider:	
Phone:	Email:
Date of referral:	

Agreement by parties at the workplace

I agree to the terms of this return to work program.	
Worker's signature:	Date:
Employer's signature:	Date:
Name of person signing on behalf of employer:	
Position of person signing on behalf of employer:	

Copies to:

Treating practitioner:	Employee: