

RETURN TO WORK PROGRAM

Is this the worker's first return to work program? Yes No

If no, Return to Work Program number: _____

Section 1 – Participant details

Worker

Name: _____

Claim number: _____

Address: _____

Phone number: _____

Email address: _____

Pre-injury position: _____

Pre-injury hours per week: _____

Site/ location/ department: _____

Type of shift/roster: _____

Employer

Employer: _____

Address: _____

ABN: _____

Supervisor: _____

Phone number: _____

Email address: _____

Program coordinator: _____

Coordinator phone number: _____

Coordinator email address: _____

Treating medical practitioner

Name:

Address:

Phone number:

Email address:

Insurer

Insurer:

Contact person:

Phone number:

Email address:

Workplace rehabilitation provider

Note: *These details are only required if a referral has been made to an approved workplace rehabilitation provider.*

Provider:

Consultant:

Phone number:

Email address:

Date of referral:

Host employer

Note: *These details are only required if the Return to Work Program includes duties to be undertaken with a host employer.*

Host employer:

Address:

ABN:

Supervisor:

Phone number:

Email address:

Section 2 – Return to Work Program

Work capacity (indicated on the certificate of capacity)

Certificate of capacity date: _____

Description of work capacity: _____

Description of work restrictions: _____

Date of next review: _____

Return to work goal

- Same Employer / Same Duties New Employer / New Duties
- Same Employer / Modified Duties Other Workplace Rehabilitation Options
- Same Employer / New Duties

Description of return to work goal: _____

Start date: _____

Review date: _____

Working hours (start and finish times)

Week commencing	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total hours

RTW program duties: _____

RTW program restrictions: _____

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

Action	Person Responsible	Completion/ Review Date

Section 3 – Worker’s agreement

I agree to the content of this Return to Work Program.

Worker signature:

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Date:

.....

Treating medical practitioner
signature (optional):

.....

Date:

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