RETURN TO WORK PLAN

Plan number

Date from D D / M M / Y Y to D D / M M / Y Y

Injured Person

Claim number

Date of injury D D / M M / Y Y

Diagnosis / Nature of injury

Employer contact name

Address

Postcode

Phone number

Email address

Name of Employer Injury Management Co-ordinator

Phone number

Email address

Insurer

Claims Consultant

Phone number

Email address

Name of Medical Provider

Phone number

Email address

Please ensure all pages are completed

Pre-injury position

Description of pre-injury duties

Pre-injury hours

Return to work goal e.g. same employer / pre-injury duties

Current medical certificate Date from D D / M M / Y Y to D D / M M / Y Y

Current work capacity / restrictions

Work timetable

Location

Week commencing	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total hours

Duties

Please ensure all pages are completed

Restrictions / tasks to be avoided

Supports to enable the return to work

Appointments and treatment

Injured Person's responsibilities

- To advise your supervisor as soon as possible if unable to attend work
- To advise your supervisor if you experience any increase in symptoms or difficulties completing this program
- Attend all scheduled appointments for your recovery
- To actively participate in this program including the development and review of the program

Employer responsibilities

- To monitor and facilitate the program within the workplace
- Provide suitable duties and relevant supports to enable a safe return to work where reasonably practicable
- Develop and review this program regularly in consultation with our employee

Plan review

Date D D / M M / Y Y

Where

Prepared by

Plan review

The following parties agree to the RTWP

Employer

Date

D D / M M / Y Y

Employee

Date

D D / M M / Y Y

Medical Practitioner

Date

D D / M M / Y Y

A copy of this RTW Plan is to be provided to the Treating Medical Practitioner, Insurer, Employer and Injured Worker.