Workers Compensation and Injury Management Act 2023

**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: |  | | |
| Date: |  | | |
| Treating medical practitioner  signature (optional): |  | | |
| Date: |  | |