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: |   |