Return to Work Plan

Surname		First Names		D.O.B.	
Job Title		Supervisor		Date of Injury	
Injury	☐ Work Related ☐ Non-Work Related	Description			

Fit for Suitable Duties ☐ Yes ☐ No	☐ Duties available	☐ Duties not available	Date

RTWP *from*		*to*	
Goal			
Employee to be Reviewed	☐ Daily ☐ Weekly	Plan due for Review (Date)	
☐ Normal hours ☐ Restricted hours	_____ hours / day	_____days / week	
Current Restrictions			
Duties			

The Rehabilitation Plan MUST be strictly adhered to – any duties not on the plan are not to be attempted. Medical restrictions must be adhered to after hours as well as whilst working. Where ever possible treatment must be sort outside working hours to provide minimal disruption to the workplace. Where your injury affects your ability to safely and efficiently evacuate in an emergency, a formal PEEP (personal emergency evacuation plan) must be lodged.

If any pain or discomfort is felt during the performance of the duties on the plan, you **MUST** cease the activity immediately and report the event to your Supervisor & the IMC. If unable to attend work during the return to work program, you **MUST** contact your Supervisor & the IMC Coordinator immediately.

I agree to monitor this plan		
IMC (Print)	Sign	Date
I agree to ensure this plan is implemented in the work area		
Supervisor (Print)	Sign	Date
I have been consulted in regard to the content of this plan and agree to adhere to and participate with it		
Employee (Print)	Sign	Date
I approve this plan		
Treating Medical Practitioner	Sign	Date