Return to Work Plan

Dispute Resolution: *If any disputes in respect of the RTW Program or RTW Plan arise, we will work together with the injured worker's RTW Group to try and resolve them. If we are unable to resolve the dispute, we will seek external assistance from the relevant State Authority.*

WORKER DETAILS			
Worker Name:	Claim No.	Job Title:	Department/Site
Address:		Phone (home):	Phone (Work/mobile):
Email:			
ORGANISATION DETAILS			
Company Name:		Address:	
Supervisor Name:	Phone (Work/mobile):	Email:	
RTW Coordinator Name:	Phone (Work/mobile):	Email:	
WORKERS COMPENSATION PROVIDER DETAILS			
Name of Insurer:		Address:	
Contact Person:	Phone (Work/mobile):	Email:	
Nominated Treating Doctor:	Address:		
Phone:		Email:	
PLAN DETAILS			
RTW Plan Start Date: RTW Plan Review Date:	**RTW Goal:**	☐ Same employer / same job ☐ Same employer / modified job ☐ Same employer / different job location	☐ Same employer / new job ☐ New employer / new job ☐ Other rehabilitation option
Work restrictions / specific work activities to be avoided - listed on the current medical certificate (if any):			

Agreed actions to be completed to enable the injured worker to RTW:	
Person responsible:	Signature:

SUITABLE DUTIES & WORK SCHEDULE

WEEK	DATE/DAY	WORK HOURS	DUTIES	RESTRICTIONS

General comments:

APPOINTMENTS / MEDICAL TREATMENTS SCHEDULE

Date	Time	Appointments / Medical treatments (E.g.: Doctor Physio/Specialist/RTW Coordinator/ Rehab Provider/ Other)

THE FOLLOWING PERSONS HAVE AGREED TO THE ABOVE RTW PLAN:

Injured Worker Signature:	Date:	RTW Coordinator:	Date:
Supervisor / Owner:	Date	Nominated Treating Doctor:	Date: