Worker:	<name>	Claim Number:	< if applicable>
DOI:	<date of injury>	Injury Type:	<describe injury>
Employer:		Supervisor:	<name>
Pre-injury Job Title:	<role title>	Pre-Injury Hours:	

Short description of pre-injury duties:

MEDICAL CERTIFICATE DETAILS: <see medical certificate>

PROGRAM DETAILS:

Start date: Review date:

Short Term Return to Work Goal:	**Long Term Return to Work Goal:**
❒ Pre-injury position	❒ Pre-injury position
❒ Pre-injury position modified	❒ Pre-injury position modified
❒ Alternative position	❒ Alternative position
❒ Other……	❒ Other……

Timeframes: From: To:

Current Medical Restrictions: (as per Medical certificate)

☐ Avoid repetitive lifting	☐ No use of ( ) specify body part
☐ No standing/ sitting longer than 30mins	☐ Avoid heavy lifting beyond usual limits in SWP
☐ No pulling/ pushing	☐ No reaching above ( ) shoulder level
☐ Rotate tasks every 30mins	☐ Limited driving of motor vehicles

☐ Other restrictions (Specify):

☐ Duties to be avoided (specify)

☐ Equipment/ modifications:

☐ Duties to be undertaken in Alternative position (Specify)

Hours / Days of Work:

Action Plan:

1 <name> will be responsible for providing interim duties in accordance with the medical restrictions

2 <name> shall be responsible for staying within the medical guidelines and not exceeding the return to work schedule.

3 <name> shall seek assistance for any task in excess of medical restrictions.

4 <name> to advise of all appointments to be attended and these are to be documented.

5 All parties are to ensure that all of the conditions outlined below and in this program, are adhered to.

Conditions:

1 This program is developed in consultation with the employee and <Doctor Name> the Treating Occupational Physician.

2 <name> progress will be reviewed on a regular basis.

3 <name> should stop any task immediately if symptoms are aggravated and report this to his:

- 3.1 Supervisor
- 3.2 Medical Practitioner
- 3.3 Injury Management Co-ordinator/Rehabilitation Case Team Representative

_____

4 The program outlined will be subject to alteration as the need arises. This will require consultation between the Injury Management Co-ordinator/Case Team Representative, employee, doctor and supervisor.

5 Other Conditions/ Appointment dates:

Program to be monitored by: _____

Review date:

AGREEMENT OF PARTIES

"I agree to the terms of this return to work program"

Employee's Signature: _____ Date: _____

Employer's Signature: _____ Date: _____

Medical Practitioner's Signature: _____ Date: _____

(at a minimum, verbal approval to be obtained)