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

☐ Same Employer / Modified Duties

☐ Same Employer / New Duties

☐ New Employer / New Duties

☐ Other Workplace Rehabilitation Options

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: .....