SUITABLE DUTIES AND RETURN TO WORK PLAN

Employee's Full Name:		**Phone Number:**	
Employee's Address:			
Job Title:		**Location:**	
Pre-Injury Hours:			
Managers Name:		**Phone Number:**	
Treating Medical Officer:		**Phone Number:**	
Date of Injury:			
Nature of Injury:			
Return to Work Date:			
Length of RTW Plan:			
Hours / Days of Work:		**RTW Plan Review Date:**	

Suitable Duties	Considerations / Restrictions

Is training required for any of these duties?	Yes ☐ No ☐ If **Yes** please provide details:
Specific Duties to be avoided:	
Treatment Arrangements: (dates, times, treatment service)	
General Comments:	

SUITABLE DUTIES AND RETURN TO WORK PLAN

The following parties have agreed to the above plan for suitable duties:

	Name	Signature	Date	Contact Phone
Employee:				
Manager:				
Rehabilitation and Return-To-Work Coordinator:				
Treating Medical Practitioner / Other Practitioner:				
Other: *(if applicable Union Rep, Health Safety Advisor/ Rep)*				

Clear Form