|  |  |  |  |
| --- | --- | --- | --- |
| **Worker:**   **Claim No.**  **Ph:** |  |  | **Goal – Long Term:** To be performing pre-illness/ injury duties/tasks ……. |
| **Supervisor/Manager: Ph:** |  |  | **Objectives of this Plan:** Prevent aggravation to existing illness/injury ….. |
| **Treating Medical Practitioner(s):**  **Dr. Ph:** |  |  |
|  |  | **Fit for suitable duties (restricted return to work) from:**    /    /    -    /    / |
|  |  | **Job Description:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Week** | **Duties/Tasks** | | | **Restrictions** |
| Commencing:  Hours: |  | | |  |
| **Treatment Occurring During this Plan:** | | **Training Required:** | **Plan to be Reviewed**:    /    /  *Insert Worker* is requested to immediately report to the RRTWC (Christine Przibilla) & *insert Manager* if at any stage he/she is unable to adhere to the program | |

|  |  |
| --- | --- |
| **Name (Treating Medical Practitioner):** Dr Signature:    /    /  ***(Or As per WorkCover Medical Certificate (Emailed to Dr xx on ………)***  *I approve this plan* | **Name (Worker):** Signature:    /    /  *I have been consulted about the content of this plan and agree to participate.* |
| **Name (Supervisor):** Signature: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    /    /  *I agree to ensure this plan is implemented in the work area.* | **Rehabilitation & Return to Work Coordinator**: Christine Przibilla Signature:    /    /  *I agree to monitor this plan.* |