|  |  |  |  |
| --- | --- | --- | --- |
| **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.*  |