WorkCover QUEENSLAND

Forklift Operator : Return to Work Checklist and Plan

Please complete with your patient

Worker name: ______________________ Claim number:_______________ Injury: ______________________

Worker will be able to participate in the duties as below from: / / to / /

Full time ☐ Part time ☐ ______hours per day _____days/week

N.B. Based on your information, a suitable duties plan will be established at the worker's place of employment. In the absence of task availability at their usual workplace the worker will continue to be paid weekly compensation and WorkCover will source suitable alternative workplace rehabilitation with a host employer.

Please consider the "health benefits of good work" and focus on what your patient can do.

Tick if suitable	Job Tasks	Limitations/Comments
	Setting up and planning for forklift usage - inspect ground / path for obstacles, danger	
	Operating forklift controls - indoors / outdoors	
	Maintaining inventory / stock control	
	Walking	
	Sitting	
	Lifting - specify weight limit	
	Driving (twisting, moving neck)	
	Stacking pallets using forklift	
	Inspecting forklift for wear and damage	
	Undertaking minor repairs and adjustments to forklift	
	Performing routine maintenance on forklift - check oil, tyres	
	Wearing PPE - advise of any restrictions (gloves, mask, goggles)	
Tick if suitable	**Alternate duties**	**Limitations/Comments**
	Traffic and pedestrian management	
	Order picking - specify weight limit	
	Assemble packaging - boxes, packages, cartons	
	Administration - filing, shredding, archiving, answering telephones, computer work. Seated or standing positions, one handed tasks available.	
	General cleaning - dusting, sweeping, mopping, removing rubbish, remove cobwebs, clean windows. One handed tasks available.	
	Desktop or classroom training	
	Safety inspections	

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If none of the above tasks or alternate duties are appropriate at this time, please advise a review date or timeframe to some form of return to work _____________________________________ / _____ / _____

☐ Please tick here if you have been unable to identify any tasks and you would prefer an allied health provider to help implement a return to work plan.

Other comments:

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SIGNATURES

Treating Medical Practitioner: ____ / _____ / _____

Worker: ____ / _____ / _____

Employer: ____ / _____ / _____

Submission and payment for this form (WorkCover Queensland claims only)

If this form is requested as part of a workers' compensation claim, please forward this completed form via our online services, or alternatively by faxing to 1300 651 387. You can charge for a "completed form" under the relevant table of costs, found on our website worksafe.qld.gov.au. This form will become part of a claim file and may therefore be read by claims staff, WorkCover Queensland's network of advisory doctors, specialists at the Medical Assessment Tribunal or during legal proceedings.

In addition, the form that you provide may be released to another person (usually the worker or employer) under the Right to Information Act (2009), the workers' compensation legislation or as authorised or required by law.