Form 031

Suitable duties program

Injured worker details

Worker: _____ Phone number:
Supervisor: _____ Phone number:
Treating medical practitioner: Phone number:

Plan details

Goal – long term:
Objective of this plan: Duration of this plan: from to
Fit for suitable duties (restricted return to work?) from: to:
Job description:

Task details

Week	Duties	Restrictions
Week 1 – commencing: _____ Hours: _____ Days:		
Week 2 – commencing: _____ Hours: _____ Days:		

Treatment occurring during this plan (e.g. physiotherapy):	Training required: ☐ Yes ☐ No
	If 'Yes', given by on
Plan to be reviewed:	

Signatures

Name (treating medical practitioner): I approve this plan Signature: _____ _____	Name (worker): I have been consulted about the content of this plan and agree to participate Signature: _____ _____
Name (supervisor): I agree to ensure this plan is implemented in the work area Signature: _____ _____	Name (rehabilitation and return to work coordinator): I agree to monitor this plan Signature: _____ _____