WorkCover QUEENSLAND

Stable Hand : 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
	Assist with grooming	
	Mixing and preparation of feed and water, preparation of all horse	
	Handle cleaning and maintain all horse and exercise equipment	
	General cleaning duties (sweeping/hosing/raking, inventory control, tidying, sorting) all company work vehicles, floats and trailers	
	Cleaning training equipment	
	Cleaning stables and hatcheries, storing bedding and performing minor repairs on fixtures, buildings and fences	
	Assisting with maintaining the health and welfare of livestock	
	Driving tasks (please comment on size of vehicle & any limits on time behind wheel)	
	Exercising horses by walking, riding, leading and swimming, and attending to horses at track work, barrier trials and races	
	Patrolling, inspecting and reporting on the condition of livestock	
	Assisting with maintaining the health and welfare of livestock	
	Assembling, preparing and storing horse gear	
	Assist with general administrative duties - filing, data entry, answering phones	

Worker name: _____ Claim number:_____ Injury: _____

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:

_____

_____

_____

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.