WorkCover QUEENSLAND

Administration Officer : 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
	Sitting or standing at work station to answer phone, perform computer work, data entry, report writing.	(alternate between sit/stand, regular breaks from typing, mousing etc & left/right handed work)
	Bending/twisting - for example bending for lower level cabinet drawers.	
	Compiling documentation - can be performed sitting or standing and requires gathering documentaion.	
	Filing - organising & collating paperwork, photocopying, printing etc.	
	Lifting & moving - for example moving paperwork/files, pulling and pushing of boxes/papers/folders.	
	Communicating with patients/clients, attending meetings and providing advice and information.	
	Psychological restrictions	
	Liasing with colleagues and patients	
	Problem solving/negotiating	
	Ability to maintain concertration and take direction	
	Time management with tasks - meet deadlines.	
	Learn and retain new information	
	Flexibility and adaptability	
	Hours of work	
	Morning shift - YES / NO - - - HOURS:	
	Afternoon shift - YES / NO - - - HOURS:	
	Night shift - YES / NO - - - HOURS:	

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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.