

Real Estate Agent : 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
	Accepting and listing properties and businesses for sale and lease, conducting inspections, and advising buyers on the merits of properties and businesses and the terms of sale or lease	
	Advising vendors of sales and marketing options such as sale by auction and open house inspections	
	Cataloguing and detailing land, buildings and businesses for sale or lease and arranging advertising	
	Assessing buyers' needs and locating properties and businesses for their consideration	
	Offering valuations and advice for buying and selling properties and businesses, and structuring the terms of settlement	
	Collecting and holding rent monies from tenants, and remitting to owner on agreed basis	
	Monitoring and addressing non-compliance with terms and conditions of tenancy and pursuing rental arrears	
	Developing and implementing business plans, budgets, policies and procedures for the agency	
	May arrange finance, land brokerage, conveyancing and maintenance of premises	

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.