WorkCover QUEENSLAND

Bank Teller : 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**
	Greeting customers, identifying their needs and answering customer inquiries	
	Ensuring customers' forms are filled in correctly and checking customers' identification	
	Accepting cash and cheques deposited by customers, verifying records and receipts, and crediting customers' accounts	
	Paying money to customers according to advice slips, cheques and negotiable documents, and debiting customers' accounts	
	Providing change, cashing cheques and recording transactions	
	Opening and closing accounts for customers	
	Balancing cash and advising supervisors of cash position and discrepancies	
	Explaining and promoting bank services to customers and referring them to appropriate financial services	

Tick if suitable	**Alternate duties**	**Limitations/Comments**

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:

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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.