

Call / Contact Centre Operator or Customer Service 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
	Answering incoming calls, emails and messages, and assisting customers with their specific inquiries	
	Identifying requirements and recording information into computer systems	
	Coaching staff and assisting call centre operators to resolve problems and customer inquiries	
	Developing rosters and managing staff numbers to meet work flows	
	Listening to calls conducted by call centre operators and providing performance feedback	
	Monitoring and timing calls	
	Creating further interest in goods and services by offering customers more information about goods and inviting customers to use services on offer	
	Updating databases to reflect changes to the status of customers and prospective customers	
	Arranging the despatch of goods, information kits and brochures to customers and interested parties	
	Undertaking clerical duties, such as faxing, and filling out paperwork, and liaising with other departments associated with completing the customer contact	
	Issuing invoices and receiving electronic payments for goods and services provided	

Worker name: _____ Claim number: _____ Injury: _____

Tick if suitable	Alternate duties	Limitations/Comments

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.