|  |  |  |
| --- | --- | --- |
| **Injured worker details** |  | **Plan details** |
| **Worker** | …… | Goal – long term: …… |
| **Claim number** | …… | Plan completed by: Employer/Provider/Insurer |
| **Phone** | ……  | Objective of this plan: …… |
| **Supervisor** | …… | Duration of this plan |
| **Phone** | …… | From: | …… | To: | …… |
| **Treating medical practitioner** | Fit for suitable duties (restricted return to work) |
| …… | From: | …… | To: | …… |
| **Phone** | …… | Job description: …… |

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| --- |
| **Task details** |
| **Week** | **Duties** | **Restrictions** |
| Week 1 – commencing: …… | …… | …… |
| Days: …… |
| Hours: …… |

|  |  |  |
| --- | --- | --- |
| Week 2 – commencing: …… | …… | …… |
| Days: …… |
| Hours: …… |

|  |  |  |
| --- | --- | --- |
| Week 3 – commencing: …… | …… | …… |
| Days: …… |
| Hours: …… |

|  |  |  |
| --- | --- | --- |
| Week 4 – commencing: …… | …… | …… |
| Days: …… |
| Hours: …… |

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment occurring during this plan (e.g. physiotherapy): | Training required:  | Yes  | No  |
| …… | If ‘Yes’, given by: …… |
| Plan to be reviewed on: …… | Training given on: …… |

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| --- |
| **Signatures** |
| **Treating medical practitioner** | **Worker** |
| Name: …… | Name: …… |
| I approve this plan. | I have been consulted about the content of this plan and agree to participate. |
| Signature: | Signature: |
| Date signed: …… | Date signed: …… |
|  |  |
| **Supervisor** | **Rehabilitation and return to work coordinator** |
| Name: …… | Name: …… |
| I agree to ensure this plan is implemented in the work area. | I agree to monitor this plan. |
| Signature: | Signature: |
| Date signed: …… | Date signed: …… |
|  |  |

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