RISKCOVER TEMPLATE FOR A RETURN TO WORK PROGRAM

RETURN TO WORK PROGRAM

WORKER DETAILS

Worker's Name:

Email/Telephone No: (home):

Email/Telephone No: (work):

Position Title:

Section:

EMPLOYER DETAILS

Employer/Business Name:

Supervisor:

Email/Telephone No:

Person coordinating return to work program:

Position:

Email/Telephone No:

INSURER DETAILS

Insurer managing the claim: RiskCover

Claim No:

Contact person:

Email/Telephone No:

MEDICAL DETAILS

Worker's Treating Medical Practitioner:

Address:

Email/Telephone No:

Facsimile No:

RETURN TO WORK GOAL

[ ] Same Employer/Same Job

[ ] Same Employer/Modified Job

[ ] Other rehabilitation options

[ ] Same Employer/New Job

[ ] New Employer/New Job

PROGRAM DETAILS

Start Date:

Review Date:

Week	Date	Hours of work	Duties	Restrictions

Work Restrictions/Special Needs (if any):

ACTIONS TO BE COMPLETED TO ENABLE THE INJURED WORKER TO RETURN TO WORK

Item No.	Action	Person Responsible	Completion/Review Date

VOCATIONAL REHABILITATION DETAILS

Note: These details are only included if the worker, the employer and the treating medical practitioner have agreed to a referral to an approved vocational rehabilitation provider.

Worker's Approved Vocational Rehabilitation Provider:

Email/Telephone No:

Date of Referral:

AGREEMENT BY PARTIES AT THE WORKPLACE:

I agree to the terms of this return to work program.

Worker's Signature: ______________________________

Date: ______________________________

Employer's Signature: ______________________________

Name of Person signing on behalf of Employer: ______________________________

Position: ______________________________

Date: ______________________________

Copies To: **Date:**

Treating Practitioner: ______________________

Employee: ______________________