|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| The following Return to Work (RTW) Plan has been developed for: | | | | | | | | | | |
| Worker: |  | | | Reference: | | | | |  | |
| Employer: |  | | | | | | | | | |
| 1. Job Title (pre injury) |  | | | | | | | | | |
| Suitable duties: |  | | | | | | | | | |
| 1. Work Location: |  | | | | | | | | | |
|  | | | | | | Suburb: | | |  |
| State: | |  | | | | Postcode: | | |  |
| 1. Supervisor: |  | | | | | | | | | |
| 1. Duties to be performed: | Details | | | | | | Considerations / restrictions | | | |
|  | | | | | |  | | | |
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|  | | | | | |  | | | |
| Specific duties to be avoided |  | | | | | | | | | |
| 1. Hours / days of work: | Week 1: |  | | | | Week 2: | |  | | |
| Week 3: |  | | | | Week 4: | |  | | |
| 1. Wages, award   *(if applicable)* |  | | | | | | | | | |
| 1. Plan Commencement Date: | /     / | | | | Length of plan: | | | /     / | | |
| 1. Review dates | /     / | | | | | | | | | |
| 1. Expected return to pre-injury duties date: | /     / | | | | | | | | | |
| 1. Current Medical Certificate: | From: | /     / | | | | To: | | /     / | | |
| 1. General Comments: |  | | | | | | | | | |

The following parties have agreed to the plan:

|  |  |  |
| --- | --- | --- |
| *Signature:* | *Include name and telephone number (if appropriate)* | |
|  | Injured Worker: |  |
|  | Supervisor: |  |
|  | Rehab Coordinator: |  |
|  | Nominated Treating Doctor: |  |
| Date: | /     / |  |

**Please complete and email or fax URGENTLY to Hotel Employers Mutual:**

**🖂:** [info@hotelemployersmutual.com.au](mailto:info@hotelemployersmutual.com.au)

**:** 02 8351 9495