|  |
| --- |
| 1. **Plan Number       -** **Details**
 |
| Employee: |       | *Job Title & Brief Description:*      |
| Phone: |       |
| Employer Contact: |       |
| Phone: |       |
| Treating Doctor: |       | *Return to Work Goal* (select one): |  |
| Phone: |       | [ ]  Return worker to their pre-injury employment with their pre-injury employer[ ]  Return worker to ‘suitable employment’ with their pre-injury employerSuitable employment role:       |
| Duration of this Plan | From: |      /     /      | To: |      /     /      |
| Certificate of Capacity Dates (max 28 days): | From: |      /     /      | To: |      /     /      |
| Next RTW Planning Meeting / Review Date: |      /     /           |

|  |
| --- |
| 1. **Suitable Duties / Suitable Employment Details**
 |
| **Stage 1 commencing:** *Dates:* */     /      to**/     /* | *Duties (including location)*           | *Required Capacity (from Work Capacity Certificate)*      |
| *Tasks to avoid:*      |  |
| Additional Considerations: |       | Days | *Sun* | *Mon* | *Tue* | *Wed* | *Thu* | *Fri* | *Sat* |
| Hours |       |       |       |       |       |       |       |
| **Stage 2 commencing:** *Dates:* */     /      to**/     /* | *Duties (including location)*           | *Required Capacity (from Work Capacity Certificate)*      |
| *Tasks to avoid:*      |
| Additional Considerations: |       | Days | *Sun* | *Mon* | *Tue* | *Wed* | *Thu* | *Fri* | *Sat* |
| Hours |       |       |       |       |       |       |       |
| **Proposed Upgrade** (subject to medical approval)*Dates:* */     /      and continuing* | *Duties:*      | *Required capacity:*      |
| Additional Considerations: |       | Days | *Sun* | *Mon* | *Tue* | *Wed* | *Thu* | *Fri* | *Sat* |
| Hours |       |       |       |       |       |       |       |
| 1. **Treatment During this Plan** (e.g. physiotherapy)
 | 1. **Training / Equipment / Modifications Required**
 |
| Type: |       | *Details:*       |
| Frequency *(times per week)*: |       |
| Number of treatments to date: |       |
| Improvements achieved: |       |

**Signatures**

|  |  |  |  |
| --- | --- | --- | --- |
| Name (Treating Doctor) |       | Name (Injured Worker): |       |
| \*Signature: |  | Date: |      /     /      | \*Signature |       | Date: |      /     /      |
| Name (Employer): |       | Name (Rehab Provider): |       |
| \*Signature: |  | Date: |      /     /      | \*Signature: |  | Date: |      /     /      |

*\* If any party does not agree to sign the Return to Work Plan then the reason for this must be noted in the signature box above*

**Please complete this form and return to Hotel Employers Mutual:**

**🖃:** GPO Box 4143, SYDNEY NSW 2001

**🖂:** info@hotelemployersmutual.com.au

**:** 02 8251 9495

***Copies*** *of this Return to Work Plan should be provided to the: Injured**Worker; Employer; Nominated Treating Doctor; any Treatment Providers involved; and any Rehabilitation Providers involved.*