|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 employer  Suitable 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](mailto: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.*