Return-to-Work Plan

Employee Details

Employee Name*: _____

Position/Job Title: _____

Department: _____

Contact Number: _____

Email: _____

Injury Details

Date of Injury*: _____

Brief Description of [illegible]*: _____

_____

Affected Body Part*: _____ > *Options: Head, Neck, Shoulder, Arm, Hand, Back, Torso, Leg, Foot, Multiple, Other*

Nature of Injury*: _____ > *Options: Sprain/Strain, Fracture, Laceration, Contusion, Burn, Illness, Other*

Treatment Provided By: _____ > *Options: First Aid, Doctor, Hospital, None*

☐ **Medical certificate provided**

Medical Assessment

Fit for Normal Duties?*: _____ > *Options: Yes, No*

Work Restrictions (if any): *(Fill only if applicable)*

_____

_____

Maximum Hours per Day: *(Fill only if applicable)*

_____

Next Medical Review Date: _____

Return-to-Work Arrangements

Plan Start Date*: _____

Plan End Date: _____

Responsible Supervisor*: _____

☐ **Modified Duties Required?**

Description of Modified Duties: *(Fill only if applicable)*

_____

_____