Return to work plan

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| --- | --- | --- | --- |
| **Employee’s name:** |  | **Date:** |  |
| **Job title:** |  | **Work location:** |  |
| **Manager/ supervisor:** |  | **Treating medical practitioner:** |  |

1. **Overarching goal of the Return to Work Plan** (SMART goal).
2. **Medical restrictions/ work activities to be avoided** (as outlined in the Fitness for Work Certificate).
3. **Reasonable specific workplace support and modifications required to achieve the goal** (e.g. flexible working hours, regular breaks, shift or location changes, adjusting the environment).
4. **Suitable work tasks** **identified.**
5. **Hours/ days of work** (include start and finish times if flexible working hours adopted).

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| --- | --- |
| **Return date:** |  |
| **Length of plan:** |  |
| **Review date:** |  |

The following parties have agreed to this Return to Work Plan. If any problems occur in completing tasks, they will be immediately communicated to the employee’s supervisor/ manager. A copy of the completed Return to Work Plan should be sent to all parties.

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| --- | --- |
| **Employee’s Name:** | |
| **Employee’s Signature:** | **Date:** |

|  |  |
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| **Supervisor’s Name:** | |
| **Supervisor’s Signature:** | **Date:** |

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| --- | --- |
| **Return to Work Coordinator’s Name:** | |
| **Return to Work Coordinator’s Signature:** | **Date:** |

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| **Treating Doctor’s Name:** | **Date:** |

**Disclaimer**

This document is not intended to be used for an employee who is returning to work following a workplace injury or illness (workers compensation claim) and for whom the Return to Work Plan documentation requirements should be confirmed with the Workers’ Compensation Agent and/or relevant Regulator/Insurer.