APPENDIX IV

RETURN-TO-WORK PLAN

Workers Name: _____ **Position Title:** _____
Date of Injury: _____ **Work Location:** _____
Nature of Injury: _____ **Supervisor:** _____
Date Plan Prepared: _____
Rehabilitation Goal (e.g. return to full pre-injury duties)**:**

Rehabilitation Plan Effective from: _____ **to** _____
STAGE I Duties to be performed:

Duties to be provided:
1. _____
2. _____
3. _____

Medical Restrictions:
1. _____
2. _____
3. _____

Other Considerations:

STAGE II
Duties to be performed:

Duties to be provided:
1. _____
2. _____
3. _____

Medical Restrictions:
1. _____

2. _____
3. _____

Other Considerations:

Monitored by: _____
Contact No: _____

Review Date: Occupational Health Advisor _____will review you on or before _____

Please ensure this appointment is kept.

This plan has been developed in consultation with the injured worker, his/her supervisor, his / her treating G.P. and other health care Professionals.

The following partners agree to the Return to Work Plan:

Injured Worker: _____ **Date:** _____
Supervisor: _____ **Date:** _____
Occupational Health Advisor: _____ **Date:** _____
Other Health Professional: _____ **Date:** _____
Other Health Professional: _____ **Date:** _____
Other Health Professional: _____ **Date:** _____

Please sign and return to the Occupational Health Department.

_____ **Occupational Health Advisor / Occupational Health Physician**