

**Return to / Recover at Work Plan #\_\_\_\_\_**

**Injured Part Details:**

Name	
Date of Birth	
Injury/Diagnosis	
Date of Injury	
Contact Phone	
Claim Number	

**Employment Details:**

Pre-Injury Role	
Pre-Injury Ave Hours	
Pre-Injury Work Location	
Pre-Injury Supervisor	
Supervisor Contact	

**Rehabilitation Policy & Objective:**

- To facilitate the worker's return to their pre-injury hours and duties in a timely, effective and durable manner
- Suitable duties are not a permanent offer.

**Current Medical Certificate:**

Hours Per Day	
Days per Week	
Restrictions	

Plan Details	
RTW/RAW Plan Start Date:	RTW/RAW Plan Review Date:
RTW Goal: <input type="checkbox"/> Same employer / same job <input type="checkbox"/> Same employer / modified job <input type="checkbox"/> Same employer / different job location	<input type="checkbox"/> Same employer / new job <input type="checkbox"/> New employer / new job <input type="checkbox"/> Other rehabilitation option



DOB ENTERPRISES PTY LTD  
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Revision

4

Date

18.03.19

Document No

IMS -450-04-FOR

Page

Page 1 of 3

Suitable Duties & Work Schedule		
Date	Duties	Comments/Hours

**General Comments/ Injured Party’s Responsibilities:**

- This plan is a designed specifically as a part of the injured person’s rehabilitation and may be reviewed at any time to reflect changes in circumstances related to medical; condition
- The injured party **MUST** always comply with this plan
- The injured party will notify their Supervisor immediately if they have difficulty following the plan or medical circumstances change
- The injured party is required to provided updated certificates of capacity, including medical certificates for days missed during the plan. Note: medical certificates for non-injury related illness does not cover the missed days.
- To resume normal duties a Certificate of Capacity must be issued stating full ability/ fitness to return to pre-injury duties.
- The injured party must notify their supervisor if they change any medical facilitator such as treating Doctor.
- Medical and other appointments must be made outside of work hours where possible.

**Employer/RTW/ Responsibilities:**

- Ensure duties provided to injured party are within medical restrictions and as document on this plan
- Monitor injured party’s progress and their RTW/RAW.
- Report and address any concerns raised by the injured party immediately
- Ensure copies of this plan are signed and forwarded to all relevant parties

## Injured Party Agreement

I \_\_\_\_\_ (*Injured Party’s name*) have read the DOB Enterprises Pty Ltd Return to/Recover at Work Program. After reading the RTW/RAW Program I have had the opportunity to raise any questions or issues that required clarification with my Employer. I confirm that I understand the Return to Work Program and that I am aware that breaches of this Program will be subject to action, as per the relevant Rehabilitation and Worker’s Compensation legislation/s.

Worker’s Signature \_\_\_\_\_ Date \_\_\_\_\_



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Page

Page 2 of 3

The following persons have agreed to the above RTW/RAW Plan:

	Name	Signature	Date
Injured Worker			
Supervisor / PCBU			
RTW Coordinator			
WHS Manager			
NTD			



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Page

Page 3 of 3