**Return To Work Arrangements**These arrangements will be reviewed over time to ensure that the duties and hours are consistent with your capacity for work and are helping to progress your return to work.

**Details**

NAME OF WORKER: WORKSAFE CLAIM NUMBER:

JOB TITLE: DAYS/HOURS OF WORK:

LOCATION: NAME OF EMPLOYER:

# **Return To Work Arrangements**

## DUTIES OR TASKS TO BE UNDERTAKEN

Describe the specific duties and tasks required. Include any physical and other requirements, e.g. lifting, sitting, rotation of tasks, etc.

## WORKPLACE SUPPORTS, AIDS OR MODIFICATIONS TO BE PROVIDED

Describe workplace supports, aids or modifications, e.g. rest breaks, buddy system, special tools, equipment, training, etc.

## SPECIFIC DUTIES OR TASKS TO BE AVOIDED

Describe the specific duties and tasks that are to be avoided or restricted, e.g. no loading pallets, tasks that are only to be undertaken with the assistance of another worker.

## MEDICAL RESTRICTIONS

Describe the restrictions on the most recent Certificate of Capacity or from other sources, e.g. phone call with the worker’s treating health practitioner, other medical information provided by the WorkSafe Agent. What date or for what period(s) do these restrictions apply?

## HOURS OF WORK

It is recommended that where reduced hours are required the hours are gradually increased where appropriate.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| WEEK 1 | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY | TOTAL P/W |
|  |  |  |  |  |  |  |  |  |
| WEEK 2 | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY | TOTAL P/W |
|  |  |  |  |  |  |  |  |  |
| WEEK 3 | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY | TOTAL P/W |
|  |  |  |  |  |  |  |  |  |
| WEEK 4 | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | SUNDAY | TOTAL P/W |
|  |  |  |  |  |  |  |  |  |

WORK LOCATION (ADDRESS, TEAM, DEPARTMENT):

SUPERVISOR (NAME, POSITION, PHONE):

PREPARED BY (NAME, POSITION, PHONE):

START DATE: REVIEWED DATE: PREPARED ON (DATE):

# **Key People Involved**

**WORKER:**

I will participate in these return to work arrangements.

NAME: PHONE: SIGNED: DATE:

**RETURN TO WORK COORDINATOR:**

I will monitor and review these return to work arrangements.

NAME: PHONE: SIGNED: DATE:

**SUPERVISOR:**

I will implement these return to work arrangements in the work area.

NAME: PHONE: SIGNED: DATE:

**TREATING HEALTH PRACTITIONER:**

These return to work arrangements are consistent with the worker’s capacity.

NAME: PHONE: SIGNED: DATE:

# **Notes (Additional Information)**