GIO Workers Compensation

Return-To-Work plan

Worker details

Claim number

Name

Injury type

Date of injury / /

Position title/section

Pre injured hours

Employer details

Business name

Supervisor

Telephone number

Email

Person coordinating return to work plan

Telephone number

Email

Insurer details

Insurer GIO

Contact person

Telephone number

Email

Medical details

Nominated treating doctor

Telephone number

Email

Return to work goal

Same employer/same job ☐ Same employer/modified job ☐ Same employer/new job ☐ New employer/new job ☐

Other vocational rehabilitation options ☐ If Ticked please specify

Plan details

Duties to be performed

Specific duties to be avoided/restrictions

Treatment arrangements (dates, times, treatment service)

GIO WORKERS COMPENSATION

16580 01/07/13 A

Plan details (continued)

Hours of work

Week	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total hours PW
Week 1 Date / /	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	
Commentary				Considerations/restrictions				
Week 2 Date / /	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	
Commentary				Considerations/restrictions				
Week 3 Date / /	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	
Commentary				Considerations/restrictions				
Week 4 Date / /	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	Start: Finish:	
Commentary				Considerations/restrictions				

Commencement date of Return-To-Work plan / /

Review dates of Return-To-Work plan / / , / /

Plan completion date / /

General comments

The following parties (as applicable) have agreed to the above return to work plan for suitable duties

Injured worker		Signature		Date	/ /
Supervisor		Signature		Date	/ /
Return-To-Work coordinator		Signature		Date	/ /
Rehabilitation provider		Signature		Date	/ /
Nominated treating doctor		Signature		Date	/ /