ROBERTSON'S REMEDIAL & PAINTING

# Form 08.3 — Return to Work Plan

| Form ID | Owner | Evidence location | Complete when |
|---|---|---|---|
| 08.3 | HR / Project Manager | HR file; project file where site restrictions apply | When suitable duties or restrictions are required |

Use: Document return-to-work arrangements, duties, restrictions and review points.

| General Details | |
|---|---|
| **Worker name:** | |
| **Claim number:** | |
| **Injury / illness description:** | |
| **Plan type:** | ☐ Initial RTW Plan ☐ Progress RTW Plan |
| **Job / PCBU:** | ☐ Same job/same PCBU ☐ Same job/different PCBU ☐ Different job/same PCBU ☐ Different job/different PCBU |
| **PCBU:** | |
| **Return to work goal:** | |
| **Date expected to achieve RTW goal:** | |
| **Pre-injury job title:** | |
| **Pre-injury days:** | |
| **Pre-injury hours:** | |
| **Services/treatment required:** | |
| **General comments:** | |

**Workers Compensation Certificate of Capacity (WCCC)**

| Capacity | Detail |
|---|---|
| **Lifting/carrying capacity** | |
| **Sitting tolerance** | |
| **Standing tolerance** | |
| **Pushing/pulling ability** | |
| **Bending/twisting/squatting ability** | |
| **Driving ability** | |
| **Other** | |
| **Commencement date:** | |

| Capacity | Detail |
|---|---|
| **End date:** | |
| **Review date:** | |

**Duties**

| Date | Duties to be performed | Days per week | Hours per day |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

The following parties have agreed to the program and understand the associated confidentiality and privacy issues within the RTW Plan:

| Party | Signature | Date |
|---|---|---|
| Injured worker: | | |
| Supervisor / manager: | | |
| RTW coordinator: | | |
| Nominated treating doctor: | | |

*Note: This Return to Work Plan is not intended to be permanent.*

**Consent Form — Release of Personal Information**

| Worker details | |
|---|---|
| **Full name:** | |
| **Claim number:** | |

| Employer details | |
|---|---|
| **Company name:** | |
| **Contact name:** | |
| **Phone:** | |
| **Email:** | |

**Worker's declaration** — I have discussed this consent form with my employer. I understand that any information collected will be kept in a confidential case file, with access restricted to those directly responsible for coordinating and monitoring my recovery at work. I understand that my employer will only collect health information relevant and necessary to manage my recovery and coordinate the claim; only use and disclose it for the purpose collected; keep it separate from my other

personnel records; take reasonable steps to protect, store and dispose of it appropriately; and allow me to access my information without unreasonable delay (unless unlawful or a serious threat to another person). I authorise and consent to the collection, use and disclosure of personal and health information relevant to managing my injury and workers compensation claim. This information may be exchanged between my employer, my treating doctor(s), the insurer, the workplace rehabilitation provider and the State Insurance Regulatory Authority (SIRA). I understand my workers compensation entitlements may be affected if I withdraw my consent.

| Consent | Signature | Date |
|---|---|---|
| Worker | | |
| Employer representative | | |