**SAmple Return to Work Plan**

[INSERT ORGANIZATION LOGO HERE]

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| Employee Name: Click here to enter text. | Claim No.: Click here to enter text. |
| Injury Date: Click here to enter text. | Pre-Injury Workplace Location: Click here to enter text. |
| Pre-Injury Position (attach job description):Click here to enter text. |

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| **RETURN TO WORK GOAL** |
| **Plan Start Date:** | **Plan End Date:** |
| Click here to enter text. | Click here to enter text. |
| **Return to Work Plan Goal (select one):** |
| [ ]  Pre-injury job[ ]  Pre-injury job, accommodated[ ]  Alternate work. If alternate work, provide position and description of work. |

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| **HEALTH RECOVERY** |
| **Accepted area(s) of injury:** |
| Click here to enter text. |
| **Is there an active treatment plan that impacts return to work?** |
| [ ]  No[ ]  Yes, provide details Click here to enter text. |
| **Treating Health Professional(s):** | **Phone Number:** |
| Click here to enter text. | Click here to enter text. |

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| **FUNCTIONAL ABILITIES** |
| **List functional abilities (what the employee can do):** |
| Click here to enter text. |
| **List precautions, if any:** |
| Click here to enter text. |

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| **PRE-INJURY JOB DUTIES** |
|  | **Yes** | **No** |
| Are the physical demands of the job within the employee’s functional abilities? |[ ] [ ]
| Are the essential duties of the job within the employee’s functional abilities? |[ ] [ ]
| **List job duties the employee can perform:** |
| Click here to enter text. |
| **List job duties the employee is unable to perform?** |
| Click here to enter text. |

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| **ACCOMMODATIONS/SOLUTIONS** |
|  | **Yes** | **No** |
| Are accommodations/modifications to the job duties required? |[ ] [ ]
| Are accommodations/modifications to the workplace/workstation required? |[ ] [ ]
| Is training required? |[ ] [ ]
| **Provide details on the type of accommodation/solution required.****Attach additional pages, as required** | **Date to be implemented** | **Expected duration** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

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| **WORK SCHEDULE** |
|  | **Days and hours scheduled each week** |  |
| **Work Week (date)** | **Mon.** | **Tues.** | **Wed.** | **Thurs.** | **Fri.** | **Sat.**  | **Sun.** | **Comments** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
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| **How will the employee be paid for the duration of the Return to Work Plan? (rate of pay, e.g. hourly)** |
| Click here to enter text. |

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| **FOLLOW UP SCHEDULE** |
| **Outline timeline/dates to monitor plan progress:** |
| Click here to enter text. |

**Signatures:**

I have agreed to this plan:

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| --- | --- | --- | --- |
| Name and Signature(Employee) |  | Date |  |
| Name and Signature(Supervisor) |  | Date |  |

**Plan Approved, if required:**

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| Name and Signature(Senior Staff Lead) |  | Date |  |