# Return to work/Stay at work Plan

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| **Employee’s Name:** |  | **Date:** |  |
| **Job title:** |  | **Work location:** |  |
| **Manager/supervisor:** |  | **Treating medical practitioner:** |  |

1. Overarching goal of the Return to Work Plan *(SMART goal)*

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1. Medical restrictions/ work activities to be avoided *(as outlined in the certificate of capacity if applicable)*

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1. Specific workplace supports and modifications required to achieve the goal *(e.g. flexible working hours, regular breaks, shift or location changes, adjusting the environment as able)*

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1. Suitable work tasks identified

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1. Hours/days of work *(include start and finish times if flexible working hours adopted*)

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Return date: ………………………………………………………...............

Length of plan: ……………………………………………………..............

Review date: ………………………………………………………...............

The following parties have agreed to this Return to Work Plan. If any problems occur in completing tasks, they will be immediately communicated to the workers supervisor/manager

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Supervisor)

\_\_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Return to Work coordinator - if applicable)

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Treating doctor)

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*A copy of this completed Return to Work Plan must be sent to all named parties.*

**Disclaimer**

*If this plan is being developed for an employee who has an accepted workers’ compensation claim, it is recommended that you confirm the Return to Work Plan documentation requirements with your workers’ compensation agent and/or relevant regulator.*

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