

DEECD Return to Work Arrangements

This Return To Work Arrangement is part of an Occupational Rehabilitation Program and does not constitute a New Contract of Employment.

Return to work
Arrangement for:

Date Arrangement
prepared:

Return to Work
Arrangement
Number:

Claim Number:

Pre-injury
Occupation:

Return to Work
Location:

Return to Work
Commencement date:

Return to Work
Review date:

Medical Restrictions: *(As per Certificate of Capacity / discussions with the Treating Health Practitioner / Independent Medical Examination)*

Return to Work Support: *(Workplace supports, aids or modifications to be provided)*

Description of Return to Work Duties: *(Team teaching, One-on-One teaching, Administrative duties, etc.)*

Working timetable:

Week Commencing:

Hours per week:

		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	
Week 1	START						
	FINISH						
Week 2	START						
	FINISH						
Week 3	START						
	FINISH						
Week 4	START						
	FINISH						

Prepared by:

Position:

Employee: I will participate in this Return to Work Arrangement

Name:

Contact Number:

Signature:

Date:

Return to Work Coordinator: I will monitor, review and implement this Return to Work Arrangement

Name:

Contact Number:

Signature:

Date:

Treating Doctor: This Return to Work Arrangement is consistent with the worker's capacity

Name:

Contact Number:

Signature:

Date: