EMPLOYEE RETURN TO WORK PLAN

NAME OF INJURED WORKER	TITLE / ROLE

SUPERVISOR NAME	DEPARTMENT / AREA

	DATE OF RETURN	TIME
YOU HAVE BEEN SCHEDULED TO RETURN TO WORK ON:		

YOU ARE WORKING WITH THE FOLLOWING RESTRICTIONS AS PER YOUR PHYSICIAN:

THE FOLLOWING REVIEW AND BRIEFING HAS OCCURRED

	The physician's restrictions have been identified and clarified.
	The supervisor is able to understand the restrictions and provide accommodated work.
	A communication pathway to get support has been provided to the injured worker.
	A review of pertinent safety policies / practices has occurred.
	A review of pertinent human resources policies, including reporting off work, clocking in / out, and similar, have been reviewed.
	The Job Demand Analysis has been reviewed in conjunction with the restrictions indicated by the physician. Duties have ben assigned as noted below.
	Requirements of the injured worker to work within restrictions have been clarified.
	Requirements of the supervisor to only assign work within restrictions have been clarified.
	Requirement of the injured worker to immediately go to their physician's office (or emergency room) if they are leaving work because they feel that they cannot perform the work or because they feel they may have been re-injured.

ASSIGNED TASKS attach separate pages as necessary

WK. NO.	ASSIGNED DUTIES	EMPLOYEE FEEDBACK	SUPERVISOR FEEDBACK	Continue Modified Duty? YES / NO	Full Return to Work? YES / NO
1					
2					
3					
4					
5					
6					
7					
8					

AGREEMENT

I, the undersigned injured worker, agree to participate in the transitional work plan described herein. I agree to consider work to be performed carefully and to work within my restrictions, ask for help when work exceeds my abilities, to notify my supervisor if there are duties assigned that exceed by abilities, or if I need assistance.

	NAME	SIGNATURE	DATE
EMPLOYEE			
SUPERVISOR			

CC: Workers' Compensation Coordinator
Supervisor file
Employee file

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