



What is a return to work program?

A return to work program is a formal program developed as part of an injury management system that may be required to assist an injured worker to remain at work or return to appropriate duties. It is a written document, developed through consultation between the employer, the injured worker and the treating medical practitioner.

A return to work program template can be downloaded from the WorkCover WA website: www.workcover.wa.gov.au

When is a return to work program required?

You are required to establish a return to work program for an injured worker if the following occurs:

- The treating medical practitioner advises in writing that a return to work program should be established.
- The medical practitioner signs a medical certificate indicating that the worker has a partial capacity to return to work.
- The medical practitioner signs a medical certificate indicating that the worker has a total capacity to return to work, but for some reason is unable to return to the position held immediately before the injury occurred.

In situations where a worker has total capacity to return to work, and has returned to the position held prior to the injury, a return to work program is not required.

Further help

Insurers are required to make their insured employers aware of their obligations in relation to establishing and implementing injury management systems and return to work programs. Insurers have an important role in assisting their insured employers with early intervention when a work injury occurs and with the establishment of appropriate return to work programs

Guidance Notes

WorkCover WA provides information that can assist you to develop your return to work program. Please see our publication *Guidance Notes for the Code of Practice (Injury Management) 2005* for easy steps to establish an injury management system in your workplace. This publication is available on our website or by phoning WorkCover WA Advisory Services on 1300 794 744.

Disclaimer

This fact sheet is intended to provide general information only. You should not act or omit to act on the basis of anything contained herein. You should seek appropriate legal/professional advice about your particular circumstances.

Return to Work Program

Worker details

Worker name: _____ Claim number: _____
 Telephone (home): _____ Telephone (work): _____
 Email: _____
 Position title: _____ Section: _____

Employer details

Employer/business name: _____
 Supervisor: _____
 Telephone: _____ Email: _____
 Person co-ordinating return to work program: _____
 Telephone: _____ Email: _____

Insurer details

Name of insurer: _____
 Contact person: _____
 Telephone: _____ Email: _____

Medical details

Name of treating medical practitioner: _____
 Address: _____
 Facsimile: _____ Email: _____
 Work restrictions on the current medical certificate (if any): _____

 Date of review by treating medical practitioner: _____

Program details

Return to work goal:

Same employer/same job
 New employer/new job
 Same employer/modified job
 Other vocational rehabilitation options
 Same employer/new job

Start date: _____ Review date: _____

Week	Date	Hours of work	Duties	Restrictions

Actions to be completed to enable the injured worker to return to work

Action	Person responsible	Completion/review date

Vocational rehabilitation details

Note: these details are only included if the worker, the employer and the treating medical practitioner have agreed to a referral to an approved vocational rehabilitation provider.

Name of approved vocational rehabilitation provider: _____
 Telephone: _____ Email: _____ Date of referral: _____

Agreement by parties at the workplace

I agree to the terms of this return to work program.

Worker's signature: _____ Date: _____
 Employer's signature: _____ Date: _____
 Name of person signing on behalf of employer: _____ Position: _____



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