To be completed by the Workplace Rehabilitation Provider if a closure report requested under standard 3.11 of the *Workplace Rehabilitation Provider Principles and Standards of Practice.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Details** | | | |
| **Name (Worker):** | | | **Claim number:** |
| **Insurer:** | | |  |
| **Employer:** | | | **Date of referral:** |
| **Return to work goal:** | | | |
| **Reason for closure** | | | |
|  | | | |
| **Work status at closure** | | | |
| **Status:** | | | **Hours per week:** |
| **Medical status** | | | |
| **Current capacity:** | | **Date of latest certificate:** | |
| **Restrictions:** | | | |
| **Costs** | | | |
| **Total costs:** | | | |
| **Summary** | | | |
|  | | | |
| **Consultant details** | | | |
| **Name:** | **Signature:** | | |
| **Phone:** | **Email:** | | |
| **Date:** | | | |