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:**  |