INDIVIDUAL RETURN TO WORK PLAN		
Workplace:	Location:	
Employee Full Name:		Date of Birth:
Claim No.:		
Job Injury:		
Date Injury Occurred:		
Phone:		
Plan Start Date:	Plan Finish Date or Event:	
Limitations:		
Physician Name:		Date Contacted:
Functional Abilities (what can the employee do):		

Return to Work Objective: (**X** in appropriate box)

	(A) Pre-injury job		(C) Return to alternate job
	(B) Pre-injury job with accommodations		(D) Other:

Specify Agreed Objective:

ACTIONS	**Due Date:**	**Review Date:**
Employee:		
Supervisor: Name:		

Modification to the work duties required?	Yes		No	
Specify:				
Training required?	Yes		No	
Specify:				
Modifications to work site required?	Yes		No	
Specify:				

Graduated Work Plan

Week	Scheduled hours/days:	Duties:
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

I have read the above notice:

Supervisor Signature Date

We have agreed to this plan:

Employee Signature Date

Plan approved:

Manager Signature Date