



Return to Work Program form

Worker details:

Worker:	Claim No.:
Address:	
Tel (hm):	Tel (mb):
Email:	
Position Title:	Area:

Employer details:

Employer:	
Address:	
Supervisor:	Tel (mb):
Email:	
Person coordinating RTWP:	
Tel (mb):	Email:

Insurer details:

Insurer: LGIS WorkCare	
Address: 170 Railway Parade, LEEDERVILLE WA 6007	
Injury Management Consultant:	
Tel (mb): 9483 8888	Email:

Medical details:

Treating Medical Practitioner:	
Address:	
Tel:	Fax:
Email:	
Date of Current Workers' Compensation Medical Certificate (WCMC):	
Date of Next Review Appointment:	

Current recommendations as per WCMC: e.g. medication, treatment and recommendations

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Current program goal:

Same employer / Same Job	RTWP Start Date:
Same employer / Modified Job	RTWP Review Date:
Same employer / New Job	

Days / hours of work:

Week Commencing	MON	TUE	WED	THU	FRI	TOTAL

Duties	Restrictions

Actions required to assist worker to RTW:

Action	Person responsible	Completion/review date

I agree that I have been involved in the development of this RTWP.	
Worker Signature:	Date:
Employer's Signature:	Date:
Name of person signing on behalf of Employer:	
Position:	

More information:

Should advice or information be required by the employer in order to complete the RTWP, then do not hesitate to contact LGIS WorkCare's Injury Management team on 9483 8888.

Further information related to the rights and responsibilities of key parties can also be gained by contacting WorkCover WA on 9388 5555.