

# Recovery at/Return to Work Plan

Non Work Related Injury or Medical Condition

TRIM	##
Date of this Plan	

## Employee details

Employee name:	
Employee number:	
Manager:	
Substantive position:	
Directorate/Team and Work Location	
Usual days/hours:	
Details of any support person including contact details	

## Injury/illness details

Injury/illness:	
Date of injury:	
Treating health practitioner:	

## Plan details

Commencement date:				
Duration of this plan:				
Commencement date:				
Next review meeting:				
Current medical capacity:	From:		To:	
Current medical restrictions:	1. 2. 3.			
STAGE ONE: Workplace adjustment				
	From:		To:	
Workplace adjustments:	1. 2. 3.			

<b>Location:</b>			
<b>Days/hours:</b>			
<b>Rest and/or meal breaks:</b>	Usual breaks as per Justice Health policy and Award entitlements		
<b>Are any Justice Health Subject Matter experts required to be involved and how?</b>			
<b>STAGE TWO: Workplace adjustment</b>			
	<b>From:</b>		<b>To:</b>
<b>Workplace adjustments:</b>	1. 2. 3.		
<b>Location:</b>			
<b>Days/hours:</b>			
<b>Rest and/or meal breaks:</b>	Usual breaks as per Justice Health policy and Award entitlements		
<b>Are any Justice Health Subject Matter experts required to be involved and how?</b>			

## Communication plan

**If you experience any difficulties during your return, either with the agreed adjustments or progress of your recovery, please contact your Supervisor/Manager immediately.**

- Your Supervisor/Manager will contact you, either in person or by phone, on a regular basis to discuss your recovery progress and any difficulties you may be experiencing with the agreed duties.
- You need to provide regular updates to your Supervisor/Manager, informing them of any changes to your condition.
- Please ensure that your medical certificates remain current and are submitted to your manager as soon as possible.
- Where any adjustments include Flexible Work arrangements, approval for that will also need to be sought

**Next worksite meeting date:**

## Agreement

The following parties acknowledge they have read, understood and agreed to this Plan.

**Employee**

Name:	Signature:	Date:
<b>Supervisor/Manager</b>		
Name:	Signature:	Date:
<b>Health Practitioner</b>		
Name:	Signature:	Date: