RETURN-TO-WORK (RTW) PLAN

Worker's name: _____

Pre-accident job position: _____

Pre-accident supervisor: _____

Modified work supervisor (if different): _____

Effective date: _____ **Anticipated end date:** _____

Job position:

- ☐ Pre-accident job – modified duties/hours
- ☐ Alternate job, with or without modifications
- ☐ Re-bundled tasks
- ☐ Home position

Functional limitations and restrictions that require accommodation:

RTW plan specifications (describe job duties, tasks and modifications, including necessary tools, equipment and training):

Hours (include progression schedule if applicable):

Days and Hours Scheduled Each Week								
Work Week (Date)	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Comments

Monitoring/review (outline schedule for regular monitoring and review):

Daily informal check-ins with supervisor at _____ (date, time, location)

Follow-up review meeting with _____ (name)

at _____ (date, time, location)

In addition, if you, the worker, employer or WorkSafeNB has any difficulties or concerns with the modified work contact, please contact:

_____

Signatures:

By signing this document, we confirm our participation in the plan's development. We understand our roles in the plan's implementation and monitoring, and agree to actively participate as outlined above.

Supervisor/manager: _____ Date: _____

Worker: _____ Date: _____

Union representative
(if applicable): _____ Date: _____