INSERT COMPANY NAME
ADDRESS
PHONE
EMAIL

RETURN-TO-WORK PLAN

Worker Name: _____

Dates of RTW Plan: From _____ To _____ Review Date: _____

Scheduled Workdays: _____

Hours of Work: _____

Treatment Appointments: _____

_____

Additional Equipment to be Provided: _____

_____

Any Additional Accommodations Required: _____

_____

_____

Activities to be Avoided: _____

_____

_____

Specific Modified Duties to be Performed:

_____

_____

_____

_____

_____

Attach HCP1 and send to Health Care Practitioner to be filled out.