***Appendix 10.4, Stay-at-work/Return-to-work Plan***

 **[Organization Name]**

**Stay-at-work/Return-to-work Plan**

**[Organization Name] will make every effort to attempt to safely accommodate an employee’s medical restriction(s) through the provision of suitable, meaningful, productive temporary modified/transitional work which is consistent with the employee’s functional abilities. [Organization Name] recognizes that work is healthy and by promoting temporary transitional, modified work through active involvement in the workplace, contributes to the employee’s physical and vocational rehabilitation.**

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|  **Employee Details** |

**Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim #:\_\_\_\_\_\_\_\_\_\_\_\_**

**Pre-Injury Job: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ Injury Date:** (dd/mm/yy) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Plan Details** |

**Plan Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Next Review Date (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Area (s) of Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Projected Plan End: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Functional Abilities** |

**Functional Abilities (what the Employee can do):**

**Limitations/Restrictions:**

**List all Duties Employee can/will perform:**

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| --- |
| **Schedule hours and days of Work** |
| **Week 1 Date: From\_\_\_\_\_\_ to \_\_\_\_\_\_\_ Days of Week : M T W T F S S** |
| **Week 2 Date: From\_\_\_\_\_\_ to \_\_\_\_\_\_\_ Days of Week : M T W T F S S**  |
| **Week 3 Date: From\_\_\_\_\_\_ to \_\_\_\_\_\_\_ Days of Week : M T W T F S S** |
| **Week 4 Date: From\_\_\_\_\_\_ to \_\_\_\_\_\_\_Days of Week : M T W T F S S** |

**We request your cooperation/agreement with the following:**

1. **If at any time during this plan, you, involved health professional(s), your Manager or designate, or the WCB deems that you are unable to perform your tasks adequately, or if your health and safety or that of your co-workers is of concern, the plan will be revised (if possible) or terminated.**
2. **You agree to :**
* **Safely perform only the duties/tasks outlined unless changes have been agreed upon by the organization and yourself.**
* **Make every effort to attend work on the days and at the times scheduled, but if for some valid reason you cannot attend work, you will follow the usual notification procedure for absence from work.**
* **Continue any treatment deemed necessary by involved health care professional(s) and attempt to arrange those appointments outside of your scheduled work hours.**
* **Notify your Manager or designate immediately if you are experiencing any problems with assigned tasks.**
* **Explain to others who may ask you to assist with or perform tasks not within your plan that you are not able to do them and will refer him/her to your Manager or designate.**
1. **You understand that temporary modified work/transitional duties may include changes in tasks or functions, hours of work or work schedules, workplace location/areas, or equipment used.**

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| **Modified Work Plan Offer** |

**I have reviewed the above Plan with my Manager (or designate) and I:**

**ACCEPT DECLINE this Plan offer.**

**Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: (dd/mm/yy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you have any problems with the duties or your progress, please contact your manager.**

**Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: (dd/mm/yy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**