*Action Required: To be completed by Rehabilitation and Return to Work Coordinator on finalisation of case.*

EMPLOYEE DETAILS

|  |  |
| --- | --- |
| **Name:**       | **Claim No:**  |
| **Occupation:**  | **Nature & Location of Injury:**  |
| **Work Location:**  | **Date of Injury:**  |

RETURN TO WORK OUTCOME

The employee has returned to work with (please tick):

#### Location Duties Hours

[ ]  Same [ ]  Same [ ]  Same

[ ]  Same (with modifications) [ ]  Modified [ ]  Reduced

[ ]  New [ ]  New

[ ]  New (with modifications)

NON RETURN TO WORK OUTCOME

[ ]  Employee is totally and permanently incapacitated for work

[ ]  Employee is partially incapacitated but cannot be placed in suitable employment through medical

 deployment

[ ]  Ill health retirement

[ ]  Employee resigned from the Department due to their health

[ ]  Employee withdrew from program or declined work

[ ]  Deceased

[ ]  WorkCover Queensland ceased program

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUMMARY OF REHABILITATION

[ ]  Workplace Rehabilitation Survey provided to employee upon finalisation of their rehabilitation

REHABILITATION & RETURN TO WORK COORDINATOR DETAILS

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:

Date of case closure:    /    /

School/Location of Coordinator: