*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: