WorkplaceNL Health Safety Compensation

Worksite Occupational Rehabilitation (WSOR) Schedule

Report date: _____

To be provided to injured worker, employer, health care providers and WorkplaceNL

Injured worker's name		**Claim number**	
WSOR Return to Work Schedule			
Weeks 1-3 (include dates, number of shifts per week, duties to be completed and duties/limitations per week)			
Weeks 4-6 (include dates, number of shifts per week, duties to be completed and duties/limitations per week)			
Weeks 7-9 (include dates, number of shifts per week, duties to be completed and duties/limitations per week)			

Estimated date of program completion: _____

Comments:

Weekly communication plan or if plan is not completed as outlined:

Contact information (email and/or phone number)		**Forwarded**
Employer contact for WSOR		Yes ☐ No ☐
Worker		Yes ☐ No ☐
Health care provider(s)		Yes ☐ No ☐
OR provider		Yes ☐ No ☐
WorkplaceNL Case Manager		Yes ☐ No ☐

Date:		Signature: