



**MAIL FORM TO:**  
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 709.778.1302  
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 workplace.nl.ca



**ESRTW**

**Early and Safe  
 Return-to-Work Plan**

This plan must be returned to WorkplaceNL within five days from receipt of functional abilities information. An updated ESRTW plan must be submitted when changes are made.

**SECTION A - GENERAL INFORMATION**

<b>1</b> Employer name	Firm number	Date of injury: <small>yyyy/mm/dd</small>	ESRTW plan type: <input type="checkbox"/> Initial <input type="checkbox"/> Subsequent <input type="checkbox"/> Revise Prior Hours
<b>2</b> Worker's last name	First name	Initial	Pre-injury job title
		Date of birth: <small>yyyy/mm/dd</small>	Claim number
<b>3</b> Is a copy of the current pre-injury job description attached?		If No, please explain:	
<input type="checkbox"/> Yes <input type="checkbox"/> No			

**SECTION B - ESRTW INFORMATION**

(See sample for instructions on completing the plan.)

<b>4</b> Is return to work appropriate?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If No, please explain:
If Yes, please complete the following:		<small>yyyy/mm/dd</small>
a) State level of hours worked (check one)		
<input type="checkbox"/> Modified (reduced) <input type="checkbox"/> Full		→ If Full, what was the date the worker returned to full hours?
b) Is the worker performing all duties of the pre-injury job with no restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If No, list essential pre-injury job duties <b>being</b> performed:		
List <b>current</b> restrictions:		
List <b>new</b> duties being performed different from the pre-injury duties:		
c) Have workplace accommodations such as assistive devices or worksite modifications been provided? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, what are they?		

**SECTION C - SUBSEQUENT PLAN (DUTIES / HOURS / STATUS)**

(Only complete for plans after the initial plan.)

<b>5</b> Have the pre-injury duties currently being performed changed since the last plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, have they: <input type="checkbox"/> Increased <input type="checkbox"/> Decreased
<b>6</b> Have the hours of work changed since the last plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, have they: <input type="checkbox"/> Increased <input type="checkbox"/> Decreased
<b>7</b> Has the return-to-work program stopped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, enter date the program stopped. <small>yyyy/mm/dd</small>

**SECTION D - RETURN-TO-WORK SCHEDULE**

8	From date <small>(yyyy/mm/dd)</small>	To date <small>(yyyy/mm/dd)</small>	Hours per day paid by employer							Gross hourly wage
			Sun	Mon	Tue	Wed	Thur	Fri	Sat	
									\$ .	
									\$ .	
									\$ .	
									\$ .	

Hours type: E - ESRTW hours P - Other paid leave

**SECTION E - ADDITIONAL COMMENTS**

<b>9</b>	Is additional documentation attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**SECTION F - SIGNATURE, CONSENT AND DECLARATION**

<b>10</b> Has the worker participated in the development of this ESRTW plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Next expected plan review date <small>(yyyy/mm/dd)</small>	<p>All employers and workers are required under the Workplace Health, Safety and Compensation Act to co-operate in the worker's early and safe return to suitable and available employment with the injury employer while the worker is receiving active medical rehabilitation for a work injury.</p> <p>I declare this plan to be complete and correct. I understand that giving false information or omitting relevant information is a serious offence.</p>	Do you want WorkplaceNL to call you? <input type="checkbox"/> Yes <input type="checkbox"/> No
If No, please explain in Section E.		Employer / representative signature	Phone number
		Date (yyyy/mm/dd)	



**Early and Safe  
Return-to-Work Plan**

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**SECTION A - GENERAL INFORMATION**

1 Employer name <i>XYZ Inc.</i>		Firm number <i>1 2 3 4 5 6 7</i>		Date of injury: yyyy/mm/dd <i>2 0 1 4 0 7 0</i>		ESRTW plan type: <input type="checkbox"/> Initial <input checked="" type="checkbox"/> Subsequent <input type="checkbox"/> Revise Prior Hours	
2 Worker's last name <i>Doe</i>	First name <i>John</i>	Initial <i>P</i>	Pre-injury job title <i>Cashier</i>	Date of birth: yyyy/mm/dd <i>1 9 7 0 0 1 0 1</i>		Claim number <i>1 2 3 4 5 6</i>	
3 Is a copy of the current pre-injury job description attached? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If No, please explain: <i>No current job description</i>					

**SECTION B - ESRTW INFORMATION**

(See sample for instructions on completing the plan.)

4 Is return to work appropriate? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If No, please explain:	
If Yes, please complete the following:		yyyy/mm/dd	
a) State level of hours worked (check one) <input type="checkbox"/> Modified (reduced) <input checked="" type="checkbox"/> Full		If Full, what was the date the worker returned to full hours?	
b) Is the worker performing all duties of the pre-injury job with no restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, list essential pre-injury job duties <b>being</b> performed: <i>regular cashier duties</i>	
List <b>current</b> restrictions: <i>avoid repetitive lifting</i>		List <b>new</b> duties being performed different from the pre-injury duties: <i>sweeping floor</i>	
c) Have workplace accommodations such as assistive devices or worksite modifications been provided? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, what are they? <i>right side cash only</i>	

**SECTION C - SUBSEQUENT PLAN (DUTIES / HOURS / STATUS)**

(Only complete for plans after the initial plan.)

5 Have the pre-injury duties currently being performed changed since the last plan? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, have they: <input checked="" type="checkbox"/> Increased <input type="checkbox"/> Decreased
6 Have the hours of work changed since the last plan? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, have they: <input checked="" type="checkbox"/> Increased <input type="checkbox"/> Decreased
7 Has the return-to-work program stopped? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If Yes, enter date the program stopped. yyyy/mm/dd

**SECTION D - RETURN-TO-WORK SCHEDULE**

8	From date (yyyy/mm/dd)	To date (yyyy/mm/dd)	Hours per day paid by employer							Gross hourly wage
			Sun	Mon	Tue	Wed	Thur	Fri	Sat	
	<i>2 0 1 4 1 2 0 1</i>	<i>2 0 1 4 1 2 0 7</i>	<i>E</i>	<i>0</i>	<i>2</i>	<i>2</i>	<i>2</i>	<i>2</i>	<i>0</i>	<i>\$ 15.00</i>
	<i>2 0 1 4 1 2 0 8</i>	<i>2 0 1 4 1 2 1 4</i>	<i>E</i>	<i>0</i>	<i>4</i>	<i>4</i>	<i>4</i>	<i>4</i>	<i>0</i>	<i>\$ 15.00</i>
	<i>2 0 1 4 1 2 1 5</i>	<i>2 0 1 4 1 2 2 1</i>	<i>P</i>	<i>0</i>	<i>8</i>	<i>8</i>	<i>8</i>	<i>8</i>	<i>0</i>	<i>\$ 15.00</i>
										<i>\$ .</i>

Hours type: E - ESRTW hours P - Other paid leave

**SECTION E - ADDITIONAL COMMENTS**

9	Is additional documentation attached? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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**SECTION F - SIGNATURE, CONSENT AND DECLARATION**

10	Has the worker participated in the development of this ESRTW plan? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If No, please explain in Section E.	Next expected plan review date <i>2 0 1 4 1 2 2 9</i> (yyyy/mm/dd)	All employers and workers are required under the Workplace Health, Safety and Compensation Act to co-operate in the worker's early and safe return to suitable and available employment with the injury employer while the worker is receiving active medical rehabilitation for a work injury. I declare this plan to be complete and correct. I understand that giving false information or omitting relevant information is a serious offence.	Do you want WorkplaceNL to call you? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		<i>John Smith</i>	<i>709-555-1111</i>	<i>2014/12/13</i>	
		Employer / representative signature	Phone number	Date (yyyy/mm/dd)	