March 2021

WorkplaceNL

MAIL FORM TO:
146-148 Forest Road
P.O. Box 9000 St. John's NL A1A 3B8
CALL US AT:
709.778.1000
1.800.563.9000

FAX FORM TO:
709.778.1302
1.800.276.5257

VISIT US AT:
workplacenl.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

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

SECTION B - ESRTW INFORMATION

(See sample for instructions on completing the plan.)

4 Is return to work appropriate? ☐ Yes ☐ No — If No, please explain:

If Yes, please complete the following:

a) State level of hours worked (check one) ☐ Modified (reduced) ☐ Full → If Full, what was the date the worker returned to full hours? yyyy/mm/dd

b) Is the worker performing all duties of the pre-injury job with no restrictions? ☐ Yes ☐ No

If No, list essential pre-injury job duties **being** performed:

List **current** restrictions:

List **new** duties being performed different from the pre-injury duties:

c) Have workplace accommodations such as assistive devices or worksite modifications been provided? ☐ Yes ☐ No

If Yes, what are they?

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? ☐ Yes ☐ No If Yes, have they: ☐ Increased ☐ Decreased

6 Have the hours of work changed since the last plan? ☐ Yes ☐ No If Yes, have they: ☐ Increased ☐ Decreased

7 Has the return-to-work program stopped? ☐ Yes ☐ 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 type	Hours per day paid by employer: Sun	Mon	Tue	Wed	Thur	Fri	Sat	Gross hourly wage
										$.
										$.
										$.
										$.

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

SECTION E - ADDITIONAL COMMENTS

9 Is additional documentation attached? ☐ Yes ☐ No

SECTION F - SIGNATURE, CONSENT AND DECLARATION

10 Has the worker participated in the development of this ESRTW plan? ☐ Yes ☐ No If No, please explain in Section E.

Next expected plan review date (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? ☐ Yes ☐ No

Employer / representative signature | Phone number | Date (yyyy/mm/dd)

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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

1	Employer name: XYZ Inc.	Firm number: 1234567	Date of injury (yyyy/mm/dd): 2014/07/07	ESRTW plan type: ☐ Initial ☑ Subsequent ☐ Revise Prior Hours	
2	Worker's last name: Doe	First name: John	Initial: P	Pre-injury job title: Cashier	Date of birth (yyyy/mm/dd): 1970/01/01	Claim number: 123456
3	Is a copy of the current pre-injury job description attached? ☐ Yes ☑ No	If No, please explain: No current job description				

SECTION B - ESRTW INFORMATION

(See sample for instructions on completing the plan.)

4	Is return to work appropriate? ☐ Yes ☑ No	If No, please explain:

If Yes, please complete the following:

a) State level of hours worked (check one) ☐ Modified (reduced) ☑ Full → If Full, what was the date the worker returned to full hours? (yyyy/mm/dd)

b) Is the worker performing all duties of the pre-injury job with no restrictions? ☐ Yes ☐ No

If No, list essential pre-injury job duties **being** performed:

regular cashier duties

List **current** restrictions:

avoid repetitive lifting

List **new** duties being performed different from the pre-injury duties:

sweeping floor

c) Have workplace accommodations such as assistive devices or worksite modifications been provided? ☑ Yes ☐ No

If Yes, what are they? right side cash only

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?	☑ Yes	☐ No	If Yes, have they:	☑ Increased	☐ Decreased
6	Have the hours of work changed since the last plan?	☑ Yes	☐ No	If Yes, have they:	☑ Increased	☐ Decreased
7	Has the return-to-work program stopped?	☐ Yes	☑ 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 type	Hours per day paid by employer: Sun	Mon	Tue	Wed	Thur	Fri	Sat	Gross hourly wage
2014/12/01	2014/12/07	E	0	2	2	2	2	2	0	$ 15.00
2014/12/08	2014/12/14	E	0	4	4	4	4	4	0	$ 15.00
2014/12/15	2014/12/21	P	0	8	8	8	8	8	0	$ 15.00
										$.

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

SECTION E - ADDITIONAL COMMENTS

9

Is additional documentation attached? ☐ Yes ☑ No

SECTION F - SIGNATURE, CONSENT AND DECLARATION

10

Has the worker participated in the development of this ESRTW plan? ☑ Yes ☐ No If No, please explain in Section E.

Next expected plan review date: 2014/12/29 (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? ☐ Yes ☑ No

Employer / representative signature	Phone number	Date (yyyy/mm/dd)
John Smith	709-555-1111	2014/12/13