

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



FSRTW

SEC						IL within five an must be so					Ret	Earl turn-to	ly and -Work		
1	Employer name		m numbe			Date of inj		yyyy/mm/do		ESRT plan ty		☐ Initial □ Subsequent ☐ Revise Prior Hours			
2	Worker's last name First name		Initial	Pre-inj	ury job titl	е	Date	of birth:	уууу	/mm/dd	С	laim num	ber		
3	Is a copy of the current pre-injury Yes If N job description attached? No	lo, ple	ease expl	ain:						'				•	
SEC	CTION B - ESRTW INFORMATION (See sa	ımple f	for instruct	ions on c	completing	the plan.)									
4	Is return to work appropriate? Yes No	lo, ple	ease expl	ain:											
If Y	Yes, please complete the following: Modified (reduced) yyyy/mm/dd										dd				
a)	State level of hours worked (check one)	— الد	→ If F	ull, what	was the	date the wo	rker retu	rned to ful	hours?	>					
l	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:														
Lis	of current restrictions:														
List new duties being performed different from the pre-injury duties:															
	Have workplace accommodations such as assistives, what are they?	/e de	vices or	worksite	e modifica	ations bee	n provid	ed?	Yes [No					
SEC.	TION C. SUBSEQUENT DI AN (DUTIES / HC	NID6	CTAT	IIC)	(Only or	mplete for p	lane after	the initial n	lan \						
5	ETION C - SUBSEQUENT PLAN (DUTIES / HO Have the pre-injury duties currently being performed	UKS	<u> </u>	<u> </u>	(Offiny CC	inplete for p	ians and		iaii.)						
6	changed since the last plan?														
7	Have the hours of work changed since the last plan?	Have the hours of work changed since the last plan? Yes No If Yes, have they: Increased Decreased yyyy/mm/dd													
	Has the return-to-work program stopped?	Ye	Yes No If Yes, enter date the program stopped.												
$\overline{}$	CTION D - RETURN-TO-WORK SCHEDULE												T 0		
8	From date To da			Hours type		Ho	ours per	s per day paid by				I	Gross hourly		
	(yyyy/mm/dd) (yyyy/mr	n/dd)	1	турс	Sun	Mon	Tue	Wed	Th	ur	Fri	Sat	Wa	age	
													\$		
													\$		
			\perp										\$		
							FORTIA	/h D	Othern	:-!			\$		
SEC	TION E - ADDITIONAL COMMENTS				Hot	urs type: E	- ESRIW	/ hours P	- Other	paid lea	ive				
9	TION E - ADDITIONAL COMMENTS										doc	dditional umentational ched?	on \square	Yes No	
	TION F - SIGNATURE, CONSENT AND DECL	.ARA													
Has the worker participated in the development of this ESRTW plan? All employers and workers are required under the Workplace Health, Safety and Compensation Act, 2022 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.									Wo	Do you want Yes WorkplaceNL No					
	Yes No If No, please														
	explain in Section E. (yyyy/mm/dd)		Empl	Employer / representative signature Phone number Date								Date (yy)	/y/mm/do	<u>d)</u>	

WorkplaceNL

2014/12/13

Date (yyyy/mm/dd)

to call you?

709-55<u>5-1111</u>

Phone number

₩ No



Has the worker participated

If No, please

explain in

Section E

in the development of this

ESRTW plan?

Yes

Next expected plan

review date

(yyyy/mm/dd)

4 1 2

2

John Smith

Employer / representative signature

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

FAX FORM TO: 709.778.1302 1.800.276.5257 VISIT US AT: workplacenl.ca



ESRTW

1.800.563.9000 Early and Safe This plan must be returned to WorkplaceNL within five days from receipt of functional Return-to-Work Plan **SECTION A - GENERAL INFORMATION** abilities information. An updated ESRTW plan must be submitted when changes are made 1 Employer name Date of injury: **ESRTW** Initial plan type: Subsequent 2 XYZ Inc. 3 Revise Prior Hours Worker's last name First name Initial Pre-injury job title Date of birth: yyyy/mm/dd Claim number P 9 0 2 3 Doe Cashier 6 John If No, please explain: Is a copy of the current pre-injury Yes job description attached? No No current job description (See sample for instructions on completing the plan.) **SECTION B - ESRTW INFORMATION** 4 | Is return to work appropriate? If No, please explain: Yes Nο yyyy/mm/dd If Yes, please complete the following: Modified (reduced) State level of hours worked (check one) 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? 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 If Yes, what are they? right side cash only SECTION C - SUBSEQUENT PLAN (DUTIES / HOURS / STATUS) (Only complete for plans after the initial plan.) Have the pre-injury duties currently being performed Increased Decreased No If Yes, have they: changed since the last plan? 6 Have the hours of work changed since the last plan? Increased Decreased If Yes, have they: yyyy/mm/dd 7 Has the return-to-work program stopped? If Yes, enter date the program stopped. SECTION D - RETURN-TO-WORK SCHEDULE 8 Gross Hours per day paid by employer Hours From date To date hourly type (yyyy/mm/dd) Sun Wed Thur Fri Sat wage (yyyy/mm/dd) Mon Tue 0 2 2 2 2 0 E 2 15.00 0 4 4 4 4 4 0 E 15.00 5 2 2 0 8 8 8 8 8 0 2 \$ 15.00 \$ Hours type: E - ESRTW hours P - Other paid leave **SECTION E - ADDITIONAL COMMENTS** 9 Is additional Yes documentation ✓ No attached? SECTION F - SIGNATURE, CONSENT AND DECLARATION 10 All employers and workers are required under the Workplace Health, Safety and Do you want Compensation Act, 2022 to co-operate in the worker's early and safe return to Yes

suitableand 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