WorkplaceNL

SEND BY FAX ONLY
f 709.778.1302
f 1.800.276.5257

CONTACT US AT:
t 709.778.1000
t 1.800.563.9000

VISIT US AT:
workplacenl.ca

Early and Safe Return-to-Work Plan

June 2016

ESRTW

SECTION A - GENERAL INFORMATION

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.

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 A - Annual leave H - Statutory holiday S - Sick leave 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 Telephone number Date (yyyy/mm/dd)

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Early and Safe Return-to-Work Plan

June 2016

ESRTW

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: 2014/07/02	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	A	0	8	8	8	8	8	0	$ 15.00
										$.

Hours type: E - ESRTW hours A - Annual leave H - Statutory holiday S - Sick leave 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

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