WorkplaceNL Health Safety Compensation

## Worksite Occupational Rehabilitation (WSOR) Progress Report

PO #:

Date of service: ___________________

| **Injured worker's name:** | | **Claim number:** | |
|---|---|---|---|
| **Reporting period** (e.g., week 4-5, July 1-12, 2024) | | | |
| **Intervention in the reporting period:** | | | |
| **Was the plan followed in the reporting period:** | | | |
| **Ongoing discrepancy between tolerances and goals:** | | | |
| **Symptoms:** | | | |
| **Concerns from/with employer and/or worker:** | | | |
| **Schedule changes required (if yes, please attach a revised schedule):** | | | |
| **WSOR intervention plan:** <br><br> **Other comments:** | | | |
| | | | |
| **Estimated date of WSOR completion:** | | | |

**Vendor Information:**

| LP name and number | | Clinic name | |
|---|---|---|---|
| Email address | | Vendor number | |
| Phone number | | Treatment site | |
| WSOR continuation request | Yes —— No—— | Number of hours and time frame | |
| Date: | | Signature: | |