## ECU_AUS_logo_C

**Details**

Edith Cowan University is committed to returning you to the workforce in your substantive position. The following return to work arrangements will provide reasonable temporary adjustments to your substantive position.

|  |  |
| --- | --- |
| **Name of worker** | **Worker’s compensation claim number (if Workers’ Compensation claim)** |
|  |  |

Pre-Injury work:

|  |  |
| --- | --- |
| **Job title** | **Days/hours of work** |
|  |  |

**Return to Work Arrangements**

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| **Duties or tasks to be undertaken** |
| *Describe the specific duties and tasks required. Include any physical and other requirements, e.g. lifting, sitting, rotation of tasks, etc.* |
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| **Workplace supports, aids or modifications to be provided** |
| *Describe workplace supports, aids or modifications, e.g. rest breaks, buddy system, special tools, equipment, training, etc.* |
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| **Specific duties or tasks to be avoided** |
| *Describe the specific duties and tasks that are to be avoided or restricted, e.g. no loading pallets, tasks that are only to be undertaken with the assistance of another worker.* |
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| **Medical restrictions** |
| *Describe the restrictions on the most recent Certificate of Capacity or from other sources, e.g. phone call with the worker’s doctor or healthcare provider, other medical information provided by the WorkSafe Agent. From what date or period(s) do these restrictions apply?* |
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| --- | --- | --- | --- | --- | --- | --- |
| **Week 1** | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Total p/w** |
|  |  |  |  |  |  |  |
| **Week 2** | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Total p/w** |
|  |  |  |  |  |  |  |
| **Week 3** | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Total p/w** |
|  |  |  |  |  |  |  |
| **Week 4** | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Total p/w** |
|  |  |  |  |  |  |  |
| **Work location***(address, team, department)* |  |

**Signature of key people involved**

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| **Worker** – *participate in these return-to-work arrangements.* |
| **Name** | **Phone** | **Signed** | **Date** |
|  |  |  |  |
| **Return to Work Coordinator** – *monitor and review these return-to-work arrangements.* |
| **Name** | **Phone** | **Signed** | **Date** |
|  |  |  |  |
| **Supervisor** – *implement these return-to-work arrangements in the work area.* |
| **Name** | **Phone** | **Signed** | **Date** |
|  |  |  |  |
| **Doctor** – *return to work arrangements are consistent with the worker’s capacity.* |
| **Name** | **Phone** | **Signed** | **Date** |
|  |  |  |  |

**Notes/additional information**

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| *If there is any additional information you wish to include in this form, please attach any supporting documentation e.g. medical reports, position description, photos etc.* |
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