Vocational rehabilitation suitable duties form

Vocational rehabilitation programs can help people with serious personal injuries maximise their recovery and return to employment. Completion of this form is necessary for the NIISQ Agency to:

- consider whether the vocational rehabilitation program is necessary and reasonable; and
- confirm insurance coverage for the program.

The NIISQ Agency provides personal accident, product and public liability insurance coverage for the duration of all NIISQ Agency approved Vocational Rehabilitation Programs.

Please email this form directly to requests@niis.qld.gov.au.

Participant Details

Name	**NIISQ case number**
Phone number	

Plan Details

Goal long term		**Objective of this plan**
Duration of this plan		
Number of weeks:	Start date:	Review date:
Prepared by *(name, position, phone number)*		

Pre-Injury work

Job title	**Days/hours of work**
Location	
Name of employer	
Description of job role	

Suitable Duties / Host employer details

Job title	Days/hours of work
Location	
Name of employer	

NIISQ Agency Insurance Coverage Confirmation

NIISQ Agency contact	Phone number
Dates covered	

Return to Work Arrangements

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.

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.

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.

Medical restrictions
Describe the restrictions on the most recent Medical Certificate or from other sources, e.g. phone call with the participant's doctor or healthcare provider. From what date or period(s) do these restrictions apply?

Task details			
It is recommended that reduced hours are gradually increased where appropriate.			
Week 1		**Duties**	**Restrictions**
Days:			
Hours:			
Week 2		**Duties**	**Restrictions**
Days			
Hours			
Week 3		**Duties**	**Restrictions**
Days			
Hours			
Week 4		**Duties**	**Restrictions**
Days			
Hours			

Signature of key people involved

Participant - *I have been consulted about the content of this plan and agree to participate.*			
Name	**Phone**	**Signed**	**Date**
Rehabilitation Provider – *I will monitor and review these return to work arrangements.*			
Name	**Phone**	**Signed**	**Date**
Supervisor – *I agree to ensure this plan is implemented in the work area.*			
Name	**Phone**	**Signed**	**Date**
Doctor – *I approve this plan.*			
Name	**Phone**	**Signed**	**Date**

Notes/additional information

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.