

HSE Health Management
Stay at Work / Return to Work Suitable Duties Plan



HSE-PRO-012b

Electronic copies of this form are current. All other copies are uncontrolled and currency can only be assured at the time of printing

Suitable Duties Plan (SDP) #	
Worker:	Ph:
Injury Diagnosis:	Claim #:
Supervisor / Manager:	Ph:
Treating Doctor:	Ph:
Plan completed by: JCU / Provider / Insurer	Duration of SDP: to
Long term RTW Goal:	Current work hours:
Objective of this SDP:	Normal work hours:
Job title:	

Task details		
Week	Duties	Restrictions
Week 1 Commencing: Days: Hours:		
Week 2 Commencing: Days: Hours:		
Week 3 Commencing: Days: Hours:		
Week 4 Commencing: Days: Hours:		

- | Recommendations |
|--|
| <ul style="list-style-type: none"> • Symptom management activities to be performed for up to 5 minutes every hour or as prescribed by treating medical professionals; • Injury Prevention and Management Advisor to be notified immediately should any difficulties or increase in symptoms arise; • Injury Prevention and Management Advisor must be advised of any program change or variation in hours worked; • Routine reviews may take place throughout the SDP to ensure adherence and ongoing progress; • Medical appointments are to be scheduled outside working hours wherever possible. |

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Suitable Duties Plan (SDP) #	Worker:
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Is a Personal Emergency Evacuation Plan (PEEP) required while on Suitable Duties: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, manager to contact HSE team to arrange.	Remuneration Details: <input type="checkbox"/> Normal Salary / Wages <input type="checkbox"/> WorkCover partially funded suitable duties <input type="checkbox"/> Income Protection (hours not worked) <input type="checkbox"/> Leave without pay (hours not worked) <input type="checkbox"/> Accrued leave entitlements
Plan to be reviewed on:	

If there are any questions / concerns regarding the stay at work / return to work suitable duties plan please contact the Injury and Prevention Management Advisor at rehab@jcu.edu.au or 4781 6182.

Signatures	
Treating Doctor	Worker
Name:	Name:
I approve this plan	I have been consulted about the content of this plan and agree to participate
Signature:	Signature:
Date signed:	Date signed:
Supervisor / Manager	Injury Prevention and Management Advisor (IPaMA)
Name:	Name:
I agree to ensure this plan is implemented in the work area	I agree to monitor this plan
Signature:	Signature:
Date signed:	Date signed: