

# Suitable Duties Plan

WHS-PRO-FORM-006d



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) # 1	
<b>Worker:</b>	<b>Ph:</b>
<b>Injury:</b>	<b>Claim #:</b>
Supervisor / Manager:	Ph:
Treating Practitioner:	Ph:
Long term RTW Goal:	Duration of SDP:
Objective of this SDP:	Current work hours:
Job title:	Normal work hours:

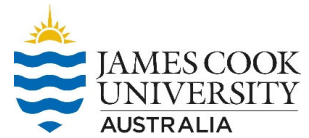
Task details		
Week	Duties	Restrictions
Week 1 Commencing:  Days: Hours:		
Week 2 Commencing:  Days: Hours:		
Week 3 Commencing:  Days: Hours:		
Week 4 Commencing:  Days: Hours:		

Additional Training Requirements:
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Recommendations
<ul style="list-style-type: none"><li>• Symptom management activities to be performed for up to 5 minutes every hour or as prescribed by treating medical professionals;</li><li>• Responsibilities are to be adhered to as per the Suitable Duties Plan Guideline;</li><li>• Routine reviews may take place throughout the SDP to ensure adherence and ongoing progress;</li><li>• Medical appointments are to be scheduled outside working hours wherever possible.</li></ul>

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Worker:

<p>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 WHS team to arrange.</p>	<p><b>Remuneration Details:</b> <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</p>
<p>Plan expiry:</p>	

If there are any questions / concerns regarding the suitable duties plan please contact the Injury and Prevention Management Advisor at [rehab@jcu.edu.au](mailto:rehab@jcu.edu.au).

Signatures	
<b>Treating Practitioner</b>	<b>Worker</b>
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:
<b>Supervisor / Manager</b>	<b>Injury Prevention and Management Advisor (IPaMA)</b>
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: