



Click on any field to start editing.

# Practitioner's Return to Work report

WCB claim number: \_\_\_\_\_

Worker's name: \_\_\_\_\_

Clinic name: _____ Clinic number: _____ Doctor number: _____ Phone: _____ Fax: _____ Practitioner's name, address, postal code	Provincial health number: _____ Date of birth: _____ Phone: _____ Employer name: _____ Worker's name, address, postal code
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## RETURN TO WORK INFORMATION

Memo to: \_\_\_\_\_ **(employer/primary practitioner/WCB)**

Please forward any requests for changes to the RTW plan to the therapist, who will monitor the worker's progress, evaluate any suggested changes, adjust the RTW plan if required, and forward amendments to all parties. The WCB will also adjust the level of income replacement as the worker's duties and hours of work change.

Return to work start date: \_\_\_\_\_ Anticipated end date: \_\_\_\_\_

Employer contact name: \_\_\_\_\_ Contact phone: \_\_\_\_\_

## HOURS AND RESTRICTIONS

### Calendar of hours and restrictions

		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week	Dates							
	Hrs							

Restrictions: \_\_\_\_\_

Comments: \_\_\_\_\_

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		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week	Dates							
	Hrs							

Restrictions: \_\_\_\_\_

Comments: \_\_\_\_\_

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		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
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Restrictions: \_\_\_\_\_

Comments: \_\_\_\_\_

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		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week	Dates							
	Hrs							

Restrictions: \_\_\_\_\_

Comments: \_\_\_\_\_

Practitioner's signature/verification: Please print & sign form before mailing/faxing. Date: \_\_\_\_\_

Employer's signature/verification: Please print & sign form before mailing/faxing. Date: \_\_\_\_\_

Worker's signature/verification: Please print & sign form before mailing/faxing. Date: \_\_\_\_\_