HEADWAY
GIPPSLAND INC.

Form – Return to Work / Work Area Assessment

This form is to be used for employees returning to work after a workplace injury, gaining employment, or returning to work after a non-work-related injury or illness with Headway Gippsland Inc.

Details

These return-to-work arrangements are for

Name of employee	
WorkSafe claim number (if applicable)	
Contact Number	

Return to Work Arrangements

Duties to be undertaken

Describe the specific duties and tasks required, including any physical and other requirements, e.g., lifting, sitting, rotating tasks, as per position description, 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 manual handling, tasks that are only to be undertaken with the assistance of another worker.

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Medical restrictions

Describe the restrictions below, including what date or what periods these restrictions apply?

Hours of work as/when appropriate in consultation with the treating medical practitioner.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Hours
Week 1								
Week 2								
Week 3								
Week 4								
Week 5								
Week 6								

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Notes/Additional Information

If you wish to include additional information in the form, please attach any supporting documentation, e.g., medical reports, position descriptions, photos, etc.

Work Area Assessment

This form is designed to help employers and employees identify existing or potential health and safety issues in work areas. This form is to be completed by the relevant manager.

Office Location	
Work Area Assessed	
Employee Present	
Date	
Name of Person Completing Assessment	
Position of Person Completing Assessment	

When completing this assessment, relevant employees within the work area

should be involved in the assessing of the task and the planning of potential risk controls

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Issue	Yes/No/NA	Recommended Solution	Person Responsible for implementing a solution	Date for Completion
Highly repetitive tasks (such as keying) performed for periods of 2 hours or more at a time				
Tasks requiring constant sitting or standing for periods of 2 hours or more at a time				
Insufficient lighting for task				
Distracting or disruptive noises present that affect the employee in the area				
Adequate space for tasks to be carried out				
Seated workstation designed for suitability for tasks done				
Seated workstation desk suitable for the tasks				
Workstation seating adequate				
Other environmental factors				

This form once completed is to be filed in the employees file (employees whose work station was assessed) on CRM.

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Key People Involved in these Return-to-Work Arrangements

Employee: *I will participate in these return-to-work arrangements*

Name	
Contact Number	
Signed	
Date	

Manager – *I will implement these return-to-work arrangements*

Name	
Contact Number	
Signed	
Date	

Treating Health practitioner – *These return-to-work arrangements are consistent with the worker's capacity.*

Name	
Contact Number	
Signed	
Date	