



Practitioner's Return to Work Report

WCB Claim # _____

Clinic # _____ **Billing #** _____ **Personal Health #** _____

Phone # _____ **Fax #** _____ **Date of Birth** DD MM YY **Phone #** _____

Employer Name _____

Practitioner's Name, Address, Postal Code

Worker's Name, Address, Postal Code

Clinic Name _____

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: DD MM YY _____

Anticipated End Date: DD MM YY _____

Employer Contact Name: _____

Contact Phone #: _____

Calendar of Hours and Restrictions

Month:		Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Week ONE	Date							
	Hrs							

Restrictions: _____

Comments: _____

Week TWO	Date							
	Hrs							

Restrictions: _____

Comments: _____

Week THREE	Date							
	Hrs							

Restrictions: _____

Comments: _____

Week FOUR	Date							
	Hrs							

Restrictions: _____

Comments: _____

Practitioner's Signature/Verification _____ **Date** DD MM YY _____

Employer's Signature/Verification _____ **Date** DD MM YY _____

Worker's Signature/Verification _____ **Date** DD MM YY _____