

EARLY AND SAFE RETURN TO WORK PLAN (ESRTW PLAN)

Date: _____

Employee's Name: _____

Claim # (or SIN): _____

Area of Injury: _____

Accident Date: _____

Last Day Worked: _____

Est. RTW to Modified duties: _____

Actual ESRTW Start Date: _____

Est. RTW to Regular duties: _____

Limitations and Restrictions: (insert date of medical)

Estimated duration of limitations:

Modified Work:

Work Schedule:

Week:	Date:	Weekly Schedule: (# of hours modified, # of hours regular duties)
1		Full hours on modified duties
2		Full hours on modified duties
3		Full hours on modified duties
4		Full hours on modified duties
5		Full hours on modified duties, with time to go to physio included
6		Full hours on modified duties, with time to go to physio included
7		Full hours on modified duties, with time to go to physio included
8		Full hours on modified duties, with time to go to physio included
9		Full hours on modified duties, with time to go to physio included
10		Full hours on modified duties, with time to go to physio included
11		Full hours on modified duties, with time to go to physio included

The worker will not incur any loss of earnings while participating in this program. Any changes to this plan must be supported by objective medical documentation and approved through WSIB. Worker and employer will participate in regular meetings to assess the progress.

Employee's Signature: _____

Date: _____

Employer's Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____