# COMMUNITY LIVING-CENTRAL HURON

## MODIFIED/GRADUATED RETURN TO WORK PLAN

Name of Employee: ____________________________________________

Position: ____________________________________________

Supervisor: ____________________________________________

Work Locations: ____________________________________________

Employee Off on: ☐ WSIB Claim ☐ Benefit Carrier ☐ Other: ____________________

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**Goal of Return to Work:**

☐ Own job on gradual basis ☐ with limitations ☐ temporary ☐ permanent ☐ unknown
☐ Other job on gradual basis ☐ with limitations ☐ temporary ☐ permanent ☐ unknown
☐ Other

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**Details of limitations and accommodations, changes to work duties:**

The restrictions and limitations listed below/attached were provided by: ______________________________
______________________________________________ and include the following:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
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____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Shift Work: ____________________________________________________________

Additional Considerations: (Safety, Training, etc.) ______________________________________________
____________________________________________________________________________

Medically Able to Drive: ☐ YES ☐ NO

Expected Date of Recovery: ____________________________________________

**Outline of Modified/Gradual Return to Work Plan:** **RTW-02**

Start Date: ________________________________ Estimated Completion Date: ____________________

| | Day 1 / #Hours Location | Day 2 / #Hours Location | Day 3 / #Hours Location | Day 4 / #Hours Location | Day 5 / #Hours Location |
|---|---|---|---|---|---|
| Week 1 | | | | | |
| Week 2 | | | | | |
| Week 3 | | | | | |
| Week 4 | | | | | |
| Week 5 | | | | | |
| Week 6 | | | | | |
| Week 7 | | | | | |
| Week 8 | | | | | |
| Other: | | | | | |

**Other:**

- Should the Employee be unable to work the above schedule or if any difficulties develop with this Return to Work Plan, the Employee will contact their Supervisor immediately.
- The Employee will seek appropriate medical attention as necessary.
- Should the Employee require a change to the Return to Work Plan, they will immediately provide the necessary medical information to the Employer, to assist with the development of a revised Return to Work Plan.
- The Employee will not take vacation time during the Return to Work Plan.
- The Employee will schedule rehabilitation activities, outside the hours noted above, to result in as little lost time as possible from their agreed upon work schedule.
- The Employer will pay the Employee for all the hours worked.
- The Employer will call the Employee at least weekly to discuss and review the Return to Work Plan.

**Statement of Understanding:**

The Employee and the Employer have discussed this Return to Work Plan.

| Employee: ________________________<br>Phone #: ________________________<br>Date: ________________________<br><br>Accept ☐ Decline ☐<br><br>Signature: ________________________ | Employer: ________________________<br>Phone #: ________________________<br>Date: ________________________<br><br>Accept ☐ Decline ☐<br><br>Signature: ________________________ |
|---|---|

Original to Supervisor

Copy To: Executive Director
Admin Coordinator
Employee