Return to Work Survey

This survey is to be completed by both the Supervisor and the employee independently, once the employee has returned to work, full hours and no modifications. Please complete within 7 days of full return to work; completed forms are given to the Administrative Coordinator.

Name of Employee: _____

Position: _____

Supervisor: _____

Work Locations: _____

Employee Off on: ☐ WSIB Claim ☐ Benefit Carrier ☐ Other - _____

What was the duration of time from the initial injury/illness report to return to work(full hours and duties)?

_____

Was there any lost time? ☐ Yes ☐ No Was there any period of modified duties? ☐ Yes ☐ No

What was the initial Return to Work Plan?:

☐ Own job ☐ with modifications ☐ temporary ☐ permanent ☐ unknown

☐ Other job ☐ with modifications ☐ temporary ☐ permanent ☐ unknown

☐ Other, Alternative work

Was the Return to Work Plan Achieved? ☐ Yes ☐ No

Why or Why not? _____

_____

Comments: _____

_____

What worked well in the Return to Work Plan? _____

_____

_____

What are the opportunities for improvement? (What would you change about the process if you could?)

_____

_____

Completed by: _____	Date: _____

Thank you for completing this survey. Confidentiality of this information will be maintained at all times. If you have any questions, please contact the Administrative Coordinator.