



SUITABLE DUTIES FORM

A key element to achieve an early and successful return to work (or maintenance at work) for an employee with a workplace injury or disease is for the workplace to be proactive in providing suitable duties within the capacity of the employee with a workplace injury or disease. This form will assist the Case Manager and workplace rehabilitation provider (WRP) to work with the employee, their supervisor and treating doctor to identify suitable duties as soon as an injury has occurred. Use this form as part of early intervention rehabilitation without waiting for the employee to lodge a claim for compensation. If a claim has been lodged this form may be used when assessing the capacity of employees with a workplace injury or disease to undertake a rehabilitation program or when developing a rehabilitation program.

The form is in three parts to enable the Case Manager or WRP (where engaged) to bring together information about the pre-injury work, potential suitable duties and medical recommendations on work capacity. The Case Manager and WRP should arrange for completion of part one and two of this form when meeting with the employee and their supervisor to discuss the employee's pre-injury duties and possible alternative duties. This information can be provided to the general practitioner to assist them in understanding the requirements of the job and make an informed decision about return to work capacity and any medical restrictions that might apply. Part three of this form is completed in consultation with the treating doctor.

WHY USE THIS FORM?

This form assists the Case Manager, WRP, treating doctor, treatment providers, the employee and their supervisor to have a shared understanding of the employee's pre-injury duties and possible options when alternative duties are required to maintain an employee in the workplace or enable an early return to work. This allows everyone to work together to facilitate a safe and durable return to work.

PRIVACY INFORMATION

Your privacy is important to us. For information about how we handle your personal information, please visit www.anu.edu.au/privacy or contact us on 02 6125 5111 and request a copy of our Privacy Policy.

AUTHORISATION AND DECLARATION

In collecting this information for the purpose of rehabilitation it is important to obtain written consent from the employee with a workplace injury or disease. The purpose of the information being obtained should also be discussed with the employee.

SUITABLE DUTIES FORM

PART 1: PRE-INJURY WORK DESCRIPTION

To be completed following discussion with the employee and their supervisor or manager

Employee	<input type="text"/>	Employer	<input type="text"/>
Case Manager	<input type="text"/>	Supervisor	<input type="text"/>
Date	<input type="text"/> / <input type="text"/> / <input type="text"/>	Claim number (if applicable)	<input type="text"/>
Pre injury hours and days	<input type="text"/>		
Job title	<input type="text"/>	Level	<input type="text"/>

What is the employee's pre-injury job? Attach duty statement/position description

What are the inherent requirements of the job e.g. essential physical, psychological and/or social demands? Do any of these requirements remain suitable if so have they been cleared by the treating GP?

Inherent requirement of the job	Frequency	Medical clearance	
		Y/N	Comment
Ad hoc activities e.g. training team meetings			

Are there any other personal factors (flags) that may delay return to work? How could they be managed to support RTW?

Are there any workplace factors (flags) e.g. conflict within the workplace that may delay return to work? How could they be managed to support RTW?

Agreed actions

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	Employee	Supervisor	Case Manager
Name			
Signature			
Date	/ /	/ /	/ /

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PART 2: POTENTIAL SUITABLE DUTIES

To be completed following a workplace assessment and discussion with the employee, supervisor or manager.

Employee	<input type="text"/>	Employer	<input type="text"/>
Case Manager	<input type="text"/>	Supervisor	<input type="text"/>
Date	<input type="text"/> / <input type="text"/> / <input type="text"/>	Claim number (if applicable)	<input type="text"/>

What modifications to pre-injury duties might be possible to enable the employee to return to work? (E.g. supervision, aids or equipment, modifications to task, volume, throughput, timeframes, work breaks)

If the employee is unable to perform pre-injury duties what other duties are available within the work team or program area? Describe.

Inherent requirement of the job	Frequency	Medical clearance	
		Y/N	Comment
Ad hoc activities e.g. training team meetings			

What other duties may be available within the organisation? Describe

If the employee is going to be off work indicate how the organisation will maintain contact?

What support will be offered to the employee with a workplace injury or disease? (E.g. Employee Assistance Program, regular communication, additional training)

Agreed actions

	Employee	Supervisor	Case Manager	WRP
Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Signature	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>

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PART 3: WORK CAPACITY

This part documents the medical opinion regarding the employee's prognosis for recovery, current work capacity and suitability for return to pre-injury or modified duties. Use this part of the form with a rehabilitation assessment to assist in developing a rehabilitation program to support the maintenance at work or return to work of an employee with a workplace injury or disease. This information does not replace a medical certificate.

Employee Case Manager

Treating doctor Date

What is the medical diagnosis and timeframe for recovery?

What is the employee's current work capacity (with reference to pre-injury work description and potential suitable duties)?

If the employee is currently unfit for work what is the medical reason they cannot return to work?

What can be done to make the workplace safer for the employee to remain at work or commence a return to work?

What hours could the employee work?

Are there any specific functional restrictions in relation to the employee's work?

Are there any other personal or environmental factors (flags) that may delay return to work and how could they be managed to facilitate RTW and prevent longer term disability?

What are the agreed actions?

In collecting this information for the purpose of rehabilitation it is important to obtain written consent from the employee with a workplace injury or disease. The purpose of the information being obtained should also be discussed with the employee.

	Medical practitioner	Employee	Case Manager	WRP
Name	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Signature	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>	<input type="text" value="/ /"/>