

# Transitional Work Program

## Individual Work Return Plan (IWRP)

This transitional work agreement has been developed by a team effort guided by the medical recommendations/ restrictions prescribed by your physician. This job assignment is within your current level of functioning. It is expected this plan will be revised as healing occurs and your level of functioning improves. Please keep your supervisor or administrator of the return to work program aware of your progress and any difficulties you may experience during this course of the work return process.

Task and schedules are subject to be revised as necessary. Job assignments shall always be compliant with your current work restrictions. Your participation in this plan will provide you with an optimum work option for recovery and safe work resumption. All members of the team shall ensure modified work is within physician prescribed work restrictions and non-compliance shall be considered a safety violation and dealt with accordingly.

We are pleased to have you back working and value your contribution. We look forward to supporting you through this transition and invite you to bring any questions you may have to our attention.

Employee Name	Prepared by:	Date Prepared
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Date of Injury:	First Day of Absence:	Next Review Date:	Projected length of plan:
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Individual Work Restriction Protection Transition One	Start Date	Name of members	Work Restrictions (Describe)
	Completion Date		

Describe the specific job tasks, methods, schedule, location, accommodations, physical demands or other details

The undersigned individuals agree to follow the work plan outlined above and fully comply with all restriction's identified by the treating medical provider. Please sign below.

Employee: \_\_\_\_\_ Supervisor: \_\_\_\_\_  
RTW Administrator: \_\_\_\_\_ Other: \_\_\_\_\_

Check if copy sent to: Physician\_\_\_ Department Manager\_\_\_ Human Resource\_\_\_ Safety\_\_\_ WC Administrator\_\_\_

<b>Individual Work Restriction Protection</b>  <b>Transition Two (if necessary)</b>	Start Date	Name of members	Work Restrictions (Describe)
	Completion Date		

Describe the specific job tasks, methods, schedule, location, accommodations and other details

The undersigned individuals agree to follow the work plan outlined above and fully comply with all restriction's identified by the treating medical provider. Please sign below.

Employee: \_\_\_\_\_ Supervisor: \_\_\_\_\_

RTW Administrator: \_\_\_\_\_ Other: \_\_\_\_\_

Check if copy sent to: Physician\_\_\_ Department Manager\_\_\_ Human Resource\_\_\_ Safety\_\_\_ WC Administrator\_\_\_

<b>Individual Work Restriction Protection</b>  <b>Transition Three (if necessary)</b>	Start Date	Name of members	Work Restrictions (Describe)
	Completion Date		

Describe the specific job tasks, methods, schedule, location, accommodations and other details

The undersigned individuals agree to follow the work plan outlined above and fully comply with all restriction's identified by the treating medical provider. Please sign below.

Employee: \_\_\_\_\_ Supervisor: \_\_\_\_\_

RTW Administrator: \_\_\_\_\_ Other: \_\_\_\_\_

Check if copy sent to: Physician\_\_\_ Department Manager\_\_\_ Human Resource\_\_\_ Safety\_\_\_ WC Administrator\_\_\_