injury management

system template

(Insert Employer/Business Name)

Injury Management Policy

(The employer) is committed to assisting injured workers to return to work as soon as medically appropriate and will adhere to the requirements of the *written Injury Management Program* in the event of a work-related injury. Management supports the injury management process and recognizes that success relies on the active participation and cooperation of the injured worker. Whenever possible, suitable duties will be arranged internally having regard for the injured worker’s medical restrictions.

Aim of the Injury Management System

To provide the best possible response to the management of workplace injuries, so injured workers can remain at work or return to work at the earliest appropriate time.

Injury Management steps

When there is an injury at work (the employer) will:

1. Take all necessary action to provide the injured worker with immediate first aid and access to appropriate medical assistance. *(Include details of the responsible person or first aid officer).*

2. Inform appropriate parties as soon as possible. *(Include contact details of workers’ compensation insurer and other key parties)*.

3. Inform the worker of the need to gain a First Medical Certificate.

4. Supply the worker with a workers’ compensation claim form.

5. Report the injury to the workers comp insurer within ?? working days.

7. Maintain close contact with the injured worker to check on progress and arrange for the worker to remain at work or return to work as soon as medically appropriate.

8. Prepare a Return-to-Work Program, in consultation with the treating medical practitioner and the injured worker, when required.

9. Refer the worker to a workplace rehabilitation1 provider when required.

10. Monitor progress towards the return-to-work goal.

11. Communicate regularly with the insurer in relation to the injured worker’s claim.

Day-to-Day Management

The person who has day-to-day responsibility for injury management is\*:

Name:

Contact Details:

Employer/Business Name:

Address:

Supervisor Telephone (work/mobile):

Email:

Person coordinating return-to-work program:

Telephone:

Email:

*\*This is either the person who has overall responsibility for injury management or*

*responsibility for a specific workplace site.*

Insurer Details

Name of Insurer:

Address:

Contact person:

Telephone:

Email:

Medical Details

Name of Treating Medical Practitioner:

Address:

Telephone:

Facsimile:

Email:

Work restrictions on the current RTW plan (if any):

Date of Review by Treating Medical Practitioner: / /

Program Details

Return to Work Goal:

Same Employer / Same Job New Employer / New Job

Same Employer / Modified Job Same Employer / New Job

Other Workplace Rehabilitation Options

Start Date: / / Review Date: / /

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Week | Date | Hrs. of Work | Duties | Restrictions |
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|  |  |  |  |  |
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Actions to be completed to enable the injured worker to return to work.

Action Person Responsible Completion/

|  |  |  |
| --- | --- | --- |
| Action | Person Responsible | Completion/Review Date |
|  |  |  |
|  |  |  |
|  |  |  |
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Vocational Rehabilitation Details

Note: *These details are only included if the worker, the employer, and the treating medical practitioner have agreed to a referral to an approved workplace rehabilitation provider.*

Name of Approved Workplace Rehabilitation Provider:

Address:

Telephone:

Email:

Date of Referral: / /

Agreement by Parties at the Workplace:

I agree to the content of this Return-to-Work Program.

Worker’s Signature:

Date: / /

Employer’s Signature:

Date: / /

Name of person signing on behalf of employer:

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_