BRONTE
COLLEGE

Return to Work Plan – Form

Confidential when completed

Employee Information

Last Name_________________________________ First Name_________________________________

Title / Department____

Manager Information

Last Name_______________________________ First Name________________________________

Title / Department____

Return to work plan start date ____________________ Return to work plan end date___________________

Goal

At the end of the return-to-work process, the Staff Member will return to his/her -

- Original job
- Original job with modifications
- Alternate job

Accommodations and Transitional measures

List any limitations the staff member experiences as a result of his/her disability, how it affects different aspects of his/her job and any accommodations or safety measures required to help the employee return to work.

Accommodations may include, but are not limited to:
- Modified work hours/days
- Modified work location
- Modified job requirements
- Assistive device(s)
- Additional support

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Limitation

Tasks/activities affected

Accommodation

Safety considerations

Start Date_______________________________ End Date______________________________________

Assignment to alternate position

This section will only be completed if the staff member will not be returning to his/her original job. The assignment to an alternate position may be temporary or permanent.

Job title Length of assignment____

Describe the new position____

List any training requirements and safety precautions____

Comments / Notes

Use this section for any additional information

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Signature

Employee's Signature_______________________________ Date________________________________

Manager's Signature________________________________ Date________________________________