|  |  |  |  |
| --- | --- | --- | --- |
|  |  | | PTSD Program  Graduated Return-to-Work (GRTW) Plan |
| Date of report (yyyy-mm-dd) | | Date of GRTW start (yyyy-mm-dd) | |

Report type (check one only)

|  |  |
| --- | --- |
| PTSD Program GRTW Plan Report (83D573)  The GRTW plan report is due no later than 5 business days prior to start of GRTW. | PTSD Program GRTW Plan Revision Report (83D574)  The GRTW plan revision report is due no later than 5 business days from the date the provider becomes aware that there are significant changes to the plan. |

Worker and claim information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Worker’s last name | Worker’s first name | Middle initial | | WorkSafeBC claim number |
| Date of injury (yyyy-mm-dd) | Worker’s occupation and/or job title | | Attending physician | |
| Claim owner’s name | | | Claim owner’s phone number | |

GRTW plan

|  |
| --- |
| Pre-injury work details (brief job description, shift structure and schedule, etc.)    GRTW plan outline, including tasks that the worker can complete and any relevant RTW factors or considerations (e.g., abilities and limitations, medical restrictions, job/task modifications, mitigating strategies, etc.)    GRTW hours and dates (please include a table in the space below)    Other (reminder: no sensitive or confidential medical information to be included) |
| The claim owner has confirmed that the GRTW plan will be conducted on the following basis:  Employer pays the worker for hours worked during the GRTW plan  WorkSafeBC pays the worker during the GRTW plan  WorkSafeBC and employer pay the worker during the GRTW plan  Not confirmed (include comments if applicable) |

Provider’s information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Provider’s name | | Payee number | Mailing address | | |
| Phone number | Fax number | | City | Province | Postal code |
| Contact’s name | Contact’s direct line (if applicable) | | Contact’s email address (optional) | | |

Report prepared by

|  |  |
| --- | --- |
| Occupational therapist’s signature | Occupational therapist’s name |
| Occupational therapist’s phone number | Occupational therapist’s email address (optional) |
| Was the injured worker involved in creating this GRTW plan?  Yes  No | If no, please explain why    Note: There should rarely, if ever, be a circumstance where the injured worker is not involved in creating the GRTW plan. |
| Was the employer involved in creating this GRTW plan?  Yes  No | If no, please explain why |

Copies to

A copy of the GRTW plan should be sent to the injured worker, WorkSafeBC, the injured worker’s physician and employer, and others as appropriate.

Worker

WorkSafeBC

Physician (do not specify)

Employer (specify)

Other (specify)

|  |  |  |
| --- | --- | --- |
| **Claims Call Centre** Phone 604.231.8888 Toll-free 1.888.967.5377 M–F, 8 a.m. to 6 p.m. | **Fax**  604.233.9777 Toll-free 1.888.922.8807 | **Mail** WorkSafeBC PO Box 4700 Stn Terminal Vancouver BC V6B 1J1 |
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WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC’s FIPP Office at PO Box 2310 Stn Terminal, Vancouver, BC, V6B 3W5, email [**FIPP@worksafebc.com**](mailto:FIPP@worksafebc.com), or call 604.279.8171.