[Company Logo] **Company Name**

Transitional Work Plan

Employee's Surname	**First Name**	☐ **Occupational** ☐ **Non Occupational**	**Date of Injury/Illness** (mm/dd/yyyy)	**Unit**
Employee's Job Title	**RTW Coordinator**	**Phone** ( ) -		**Today's Date**

Supervisor:	**Department:**

Describe Job and/or Specific Tasks:

Describe Hours per Day and Days per Week, Including Progression Schedule:

Anticipated Duration:

Special Consideration (i.e. special equipment, etc.):

_____ **Date:** _____/_____/_____ (mm/dd/yyyy)
Supervisor Signature

_____ **Date:** _____/_____/_____ (mm/dd/yyyy)
Employee's Signature

_____ **Date:** _____/_____/_____ (mm/dd/yyyy)
Physician's Signature