

DC Office of Risk Management Return to Work (RTW) Program



WORK PLAN

Name of Employee: _____

Name of Agency:				Address:	
Job Title:			Duration of Plan:		
Job Description:					
Supervisor's Name:				Supervisor's Contact #:	
Start Date:		End Date:		Pre-Injury Job Title:	
Goal:					
Day	Scheduled Hours	Hours Worked	Hours Not Worked	Issues completed by Supervisor & Worker	Resolutions completed by Supervisor & Worker
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					

Employee Signature

Date