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