

Submit to:  
 Department of Consumer & Business Services  
 Workers' Compensation Division  
 350 Winter St. NE  
 P.O. Box 14480  
 Salem, Oregon 97309-0405

# Return-to-Work Plan; Direct Employment

Date: \_\_\_\_\_ Worker: \_\_\_\_\_  
 Counselor (name, phone): \_\_\_\_\_ WCD file no.: \_\_\_\_\_  
 VRO (name, city): \_\_\_\_\_ Insurer: \_\_\_\_\_  
 Claim no.: \_\_\_\_\_  
 DOI: \_\_\_\_\_

1. Vocational objective(s):	S.O.C/D.O.T. code(s):	Expected weekly RTW wage:
_____	_____	_____
_____	_____	_____
_____	_____	_____

<b>2. Plan dates:</b> Start date: _____ Projected end date: _____	<b>3. Specific services required to meet objectives:</b>   
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<b>4. Responsibilities of worker and counselor unique to this plan:</b>   	<b>5. I understand my responsibilities under this plan and have received a copy of the plan support and both sides of this form. I understand that the Workers' Compensation Division may review the plan.</b>   <table border="0" style="width: 100%;"> <tr> <td style="width: 80%;">Worker</td> <td style="width: 20%;">Date</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>Plan developer</td> <td>Date</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>Cosigner</td> <td>Date</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>Insurer</td> <td>Date</td> </tr> <tr> <td>Insurer phone:</td> <td>_____</td> </tr> </table>	Worker	Date	_____	_____	Plan developer	Date	_____	_____	Cosigner	Date	_____	_____	Insurer	Date	Insurer phone:	_____
Worker	Date																
_____	_____																
Plan developer	Date																
_____	_____																
Cosigner	Date																
_____	_____																
Insurer	Date																
Insurer phone:	_____																

<b>6. Comments:</b>   	<b>For WCD use</b>
	<input type="checkbox"/> In conformance with OAR 436-120 Consultant _____ Date _____
	<input type="checkbox"/> Not in conformance Consultant _____ Date _____
	<input type="checkbox"/> Revised to conform Consultant _____ Date _____
	<input type="checkbox"/> Optional Consultant _____ Date _____

## **Responsibilities under Return-to-Work Plan**

### **Worker will do the following:**

- Maintain regular contact with counselor.
- Fully participate in the return-to-work plan services.
- Follow up on all job leads in a timely manner.
- Accept suitable employment if it is offered and notify counselor immediately.
- Promptly inform counselor of any problem that might affect participation.
- Meet any responsibilities agreed to in this plan.

### **Counselor will provide the following services in accordance with OAR 436-120:**

- Provide instruction on job-search skills, as necessary.
- Provide job development, as necessary.
- Provide timely, accurate progress reports to the insurer.
- Meet any other responsibilities agreed to in this plan.

### **Insurer will provide the following services in accordance with OAR 436-120:**

- Contact the Workers' Compensation Division to schedule a conference if no plan is approved within 45 days of determining the worker entitled to a direct employment plan.
- File plan with Workers' Compensation Division.
- Meet any other responsibilities agreed to in this plan.

