Logo, company name

Description automatically generated

Sira

Template - Workplace facilitated discussion action plan

State Insurance

Regulatory Authority

|  |  |
| --- | --- |
| Worker details | |
| Worker’s name |  |
| Claim number |  |
| Date of injury |  |
| Current capacity for work |  |
| Date of referral |  |
| Job title |  |
| Pre-injury hours |  |
| Employer details | |
| Employer |  |
| Employer contact person |  |
| RTW contact person |  |

# Individual meetings - preparation

|  |  |  |  |
| --- | --- | --- | --- |
| Participants | Summary of concerns and options reported | Location | Date and method of contact |
| Worker | Specify and discuss the concerns and options raised. Note any support people in attendance. |  |  |
| Employer |  |  |  |
| Other |  |  |  |

# Summary of workplace facilitated discussion meeting

|  |
| --- |
| Points of concerns and options discussed in the workplace facilitated discussion meeting |
| Outline any additional concerns issues raised |

|  |
| --- |
| Facilitator recommendations |
|  |

|  |  |
| --- | --- |
| Meeting details | |
| Date/s |  |
| Location/s |  |
| Participants | Including support people |

# Agreed action plan

This section must be completed at the conclusion of the workplace facilitated discussion intervention. If the intervention does not progress past individual meeting/s to a group meeting, the provider will be required to submit an action plan to the insurer at the conclusion of individual meetings advising that a group meeting will not be taking place.

|  |  |  |
| --- | --- | --- |
| Agreed actions | Responsibility | Timeframe |
| Detailed SMART actions (specific, measurable, achievable, relevant, time) | Outline who is responsible for actioning this | Please include a date or duration |
| Example - :  1. Parties affirmed their commitment to continue to adjust their personal behaviour(s) towards each other:   * parties agreed to practise workplace civility e.g. greeting each other each day;   party agreed to email the worker at least one day before a scheduled meeting to outline the worker’s role during that meeting. |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| Action plan to be supplied to | Confirm copies provided |
| Worker |  |
| Employer |  |
| Insurer (contact details) |  |
| Other (please specify who) |  |

|  |  |
| --- | --- |
| Stakeholders’ agreed endorsement to the action plan | Date of signature |
| Signed by (insert worker’s name here) |  |
| Signed by (insert employer’s name here) |  |
| Signed by (insert relevant party’s name here) |  |
| Signed by (insert relevant party’s name here) |  |

|  |  |
| --- | --- |
| Facilitator details | |
| Signed by (insert facilitator’s name here) |  |
| Facilitator’s qualification |  |
| Facilitator’s contact number |  |
| Facilitator’s email |  |
| Workplace rehabilitation provider name |  |
| Date |  |