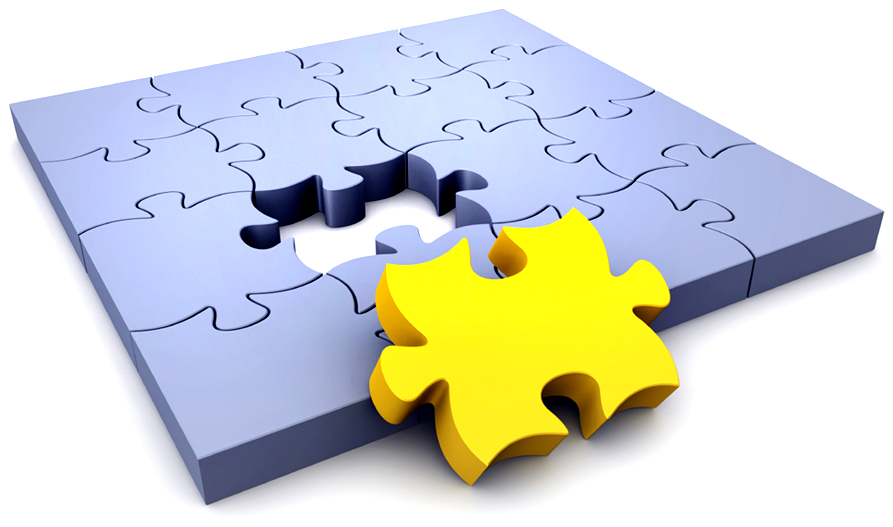
# 



**Rehabilitation & Return to Work Co-ordinator Course:**

***Course Completion Instructions***





# C:\Users\Simon\Pictures\Website 2015\Rehab Consultation.jpg

## **Instructions to the candidate:**

The Rehabilitation and Return to Work Co-ordinator Online Course requires evidence be collected in order to determine your competency. This evidence collection includes underpinning theory questions, written assessment and practical case study assessments. Your competency will be assessed as a result of the skills, knowledge and ability you demonstrate throughout this course.

The online and written assessment is to be done as an individual. You may refer to the training manual or to your notes to complete the written assessment, but you are not to discuss any questions or answers with another person.

The practical assessments during the course are presented as simulated work scenarios. If you are unsuccessful at your first attempt, you will be assessed as **Not Yet Competent**, you may be given re-training, and you will be given an opportunity to attempt an assessment again. This second assessment may be in a different format to the first.

If you have any questions, **please ask your trainer at the course or on** [**rrtwc@ohsa.com.au**](mailto:rrtwc@ohsa.com.au) **or 0755 595 440**.

**Rehabilitation & Return to Work Co-ordinator Course [*online course*]:**

**Course Checklist *(to be completed and submitted by student to assessor)***

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name of Student |  | | |
| USI | *Your Unique Student Identifier No: (see www.usi.gov.au):* | | |
| Driver’s License No. | No: State Issued: | | |
| Date of Birth |  | | |
| Address |  | | |
|  | | |
| Phone |  | Mobile |  |
| Email |  | Fax |  |

*All personal details are collected only for the purpose of issuing Statements of Attainments or qualifications. Nationally accredited course require that we keep the details below. (Full privacy policy available on request).*

**All students must complete all of the following and also tick, sign and submit this checklist to us.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Complete the provided OHSA Enrolment Form & submit copy of driver’s licence, passport or 100 points of I.D (contact our office if you need info about 100 points of I.D). | | | 🞎 |
|  | Complete each of the online modules including:   * Work within the Workers Compensation Industry Sector * Develop Return to Work Plans * Implement & Monitor Return to Work Plans | | | 🞎 |
|  | Complete the three (3) assessment workbooks for:   * Work within the Workers Compensation Industry Sector * Develop Return to Work Plans * Implement & Monitor Return to Work Plans. | | | 🞎 |
|  | Complete and submit the AQTF Learner Questionnaire (emailed to student with initial login email), Statutory Declaration (see page 5) and Assessment Summary Sheet (see Page 6). | | | 🞎 |
|  | ***Declaration (Compulsory):*** I declare that the work I have submitted for this course is my work and no-one else’s. I have not copied any other person’s or previous student’s content when completing this assessment. I understand and agree to be contacted by an assessor to answer a sample of questions from this course assessment. I understand that if I am unable to satisfactorily provide sufficient responses to these questions my qualification will either not be issued or I will be required to return it and forgo my enrolment fee. I also accept that OHSA may report any suspicious or fraudulent behaviour to the relevant regulatory bodies or statutory authorities. I agree to these terms and conditions. | | | 🞎 |
| **Signature:** | |  | **Date:** |  |

**Course Requirements**

**Step 1: You must complete *each* of the three (3) online assessments including:**

* Work within the Workers Compensation Industry Sector
* Develop Return to Work Plans
* Implement & Monitor Return to Work Plans

**Step 2: You must submit to us:**

1. Proof of identity (photographic evidence i.e. copy of driver’s licence or passport or 100 points of ID)
2. Completed OHSA Course Enrolment Form – provided with initial course login email.
3. The three (3) Assessment Workbooks completed for each of the 3 modules.
4. Completed AQTF Learner Questionnaire – separate document emailed to you at initial enrolment.
5. The front page checklist (on page 1 of this document) with ALL boxes ticked and your signature and date.
6. Completed Statutory Declaration and Assessment Summary Sheet (both included herein this document).

***Note: Please keep copies of all documentation you submit to us in case they are misplaced.***

**Step 3:**

A random sample of students will be contacted and asked a series of questions to determine that the student actually completed the study themselves. Typical online assessment questions and other study material used during the course will be used as a guide and we will expect that the student will be able to sufficiently respond to those answers/concepts. Should they not be able to correctly answer a sufficient number of those set questions we will not deem the student competent. Prior to Successful completion of Steps 2 & 3 will result in the participant being issued with a *Statement of Attainment for the unit of competency.*

**Step 4:**

The OHSA assessor will mark the online and submitted work. In the event that a participant is deemed not yet competent, you will still be contacted by OHSA to discuss options for achieving competency. The participant also has the option to appeal the assessment decision within 1 month of decision. The appeals process is outlined in the course information handout given to each candidate and the appeals form is available from the Training Coordinator at OHSA or can be found on our website at: <http://www.ohsa.com.au/student_handbook.htm>

## **Submission of your workplace evidence**

The documents/testimonial should be submitted either by post, fax or email to OHSA at the address below or [rrtwc@ohsa.com.au](mailto:rrtwc@ohsa.com.au) or facsimile on 0755 595 661. If you are mailing the material please retain a copy for your records and send the original to:

###### Training Co-ordinator - OHSA Occupational Health Services Australia Pty Ltd

32/1176 Gold Coast Highway PALM BEACH QLD 4221

(PO BOX 336 PALM BEACH QLD 4221)

E: [rrtwc@ohsa.com.au](mailto:rrtwc@ohsa.com.au)

P: (07) 55 595 440

F: (07) 55 595 661

**DUE DATE**

All course assessment tasks must be received within **three (3) months** of enrolment into our online course. If you require further time please contact our office for an extension.

**Commonwealth of Australia**

**STATUTORY DECLARATION**

***Statutory Declarations Act 1959***

*Insert the name, address and occupation of person making the declaration*

I, (name)..............................................................................................................................................................

Of, (address) ......................................................................................................................................................

In the State of (insert State) ........................................................................... Postcode ...................................

make the following declaration under the *Statutory Declarations Act 1959:*

*"That I completed and understood the OHSA online Rehabilitation and Return to Work Co-ordinator Course and all of the information contained in the course. All of the course and assessment material was completed by me and the only assistance that I might have received, if required, was by an OHSA trainer to explain any concepts that I had difficulty understanding.”*

I understand that a person who intentionally makes a false statement in a statutory declaration is guilty of an offence under section 11 of the *Statutory Declarations Act 1959*, and I believe that the statements in this declaration are true in every particular.

Signature: ............................................................................................................................................................................

*(To be signed only in the presence of a JP or CDEC)*

***To be completed by a Justice of the Peace.***

The above applicant has signed the statutory declaration in my presence and has provided photo identification (Driver’s Licence, Passport or Student Card).

Taken and Declared before me, at *(place)* ......................................................................................................

.............................................................................................................................................................................

On the *(day)*.................................... of (*month*) ........................................................and (*year*) ......................

*Full name*,...................................................................................................................................................................

*Qualification* ........................................................................................................................................................

*Address* ...............................................................................................................................................................

*of person before whom the declaration is made (in printed letters)*

Justice of the Peace stamp or signature .............................................................................................................

**A Justice of the Peace or Commissioner for Declarations**

N*ote 1* A person who intentionally makes a false statement in a statutory declaration is guilty of an offence, the punishment for which is imprisonment for a term of 4 years — see section 11 of the *Statutory Declarations Act 1959*.

*Note 2* Chapter 2 of the *Criminal Code* applies to all offences against the *Statutory Declarations Act 1959* — see section 5A of the *Statutory Declarations Act 1959*.

**ASSESSMENT SUMMARY – Rehabilitation & Return to Work Co-ordinator Course**

|  |  |
| --- | --- |
| **Student’s Name:** |  |
| **Student’s USI No:** |  |
| **Date of final assessment submitted:** |  |
| **Assessor’s Name:** | SIMON PHILLIPS |

**Office Use:**

|  |  |  |
| --- | --- | --- |
| **No.** | **Tasks** | **Completed Y or NYC or N/A** |
| **1** | Student OHSA Course Enrolment Form provided |  |
| **2** | USI No & 100 points ID provided |  |
| **3** | Three online modules completed |  |
| **4** | Three assessment workbooks completed |  |
| **5** | Statutory Declaration provided |  |
| **6** | Learner Feedback Form submitted |  |
| **7** | Assessment Summary completed |  |

|  |
| --- |
| **Assessment Decision**  I agree / disagree that the candidate has successfully demonstrated the required skills and knowledge through completion of the written assessment and practical demonstration.  Based on overall performance, I deem the candidate:  🞎 Competent  🞎 Not yet competent - please complete comments section below  **Assessor Comments:** |
| **Assessor Name:** |
| **Assessor Signature:** |
| **Date:** |
| **Candidate Sign off:**  I verify that this assessment was completed solely by myself and I have been advised regarding appeals, complaints and agree with this assessment decision.  **Comments:** |
| **Candidate Name:** |
| **Candidate Signature:** |
| **Date:** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Injured worker details | | | | | | | | | Plan details | | | |
| Worker: |  | | | Phone number: | |  | | | Goal – long term: | | | |
| Supervisor: |  | | | Phone number: | |  | | | Objective of this plan: | | | |
| Treating medical practitioner: |  | | | Phone number: | |  | | | Duration of this plan from:       to | | | |
| Job description: | | | | | | | | | Fit for suitable duties (restricted return to work?)  From:       to: | | | |
|  | | | | | | | | | | | | |
| Task details | | | | | | | | | | | | |
| **Week** | | | | | **Duties** | | | | | | **Restrictions** | |
| Week one commencing: | | | | |  | | | | | |  | |
| Hours: | | Days: | | |  | | | | | |  | |
| Week two commencing: | | | | |  | | | | | |  | |
| Hours: | | Days: | | |  | | | | | |  | |
| Treatment during this plan (e.g. physiotherapy): | | | | | | | | Training required: | | | | |
|  | | | | | | | | If ‘yes’ given by: | | | | |
| Plan to be reviewed: | | | | | | | | On: | | | | |
|  | | | | | | | | | | | | |
| **Signatures** | | | | | | | | | | | | |
| Name (treating medical practitioner): | | |  | | | | Name (worker): | | |  | | |
| I approve this plan | | | | | | | I have been consulted about the content of this plan and agree to participate | | | | | |
| Signature: | | | | | Date: | | Signature: | | | | | Date: |
| Name (supervisor) | | |  | | | | Name (rehabilitation and return to work coordinator) | | |  | | |
| I agree to ensure this plan is implemented in the work area | | | | |  | | I agree to monitor this plan | | | | | |
| Signature: | | | | | Date: | | Signature: | | | | | Date: |

**Suitable Duties Program Template (2 week)**

**Suitable Duties Program Template (3 week)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Injured worker details | | | | | | | | | Plan details | | | |
| Worker: |  | | | Phone number: | |  | | | Goal – long term: | | | |
| Supervisor: |  | | | Phone number: | |  | | | Objective of this plan: | | | |
| Treating medical practitioner: |  | | | Phone number: | |  | | | Duration of this plan from:       to | | | |
| Job description: | | | | | | | | | Fit for suitable duties (restricted return to work?) From:       to: | | | |
| Task details | | | | | | | | | | | | |
| **Week** | | | | | **Duties** | | | | | | **Restrictions** | |
| Week one commencing: | | | | |  | | | | | |  | |
| Hours: | | Days: | | |
| Week two commencing: | | | | |  | | | | | |  | |
| Hours: | | Days: | | |
| Week three commencing: | | | | |  | | | | | |  | |
| Hours: | | Days: | | |
| Treatment during this plan (e.g. physiotherapy): | | | | | | | | Training required: | | | | |
| If ‘yes’ given by: | | | | |
| Plan to be reviewed: | | | | | | | | On: | | | | |
| **Signatures** | | | | | | | | | | | | |
| Name (treating medical practitioner): | | |  | | | | Name (worker): | | |  | | |
| I approve this plan | | | | | | | I have been consulted about the content of this plan and agree to participate | | | | | |
| Signature: | | | | | Date: | | Signature: | | | | | Date: |
| Name (supervisor) | | |  | | | | Name (rehabilitation and return to work coordinator) | | |  | | |
| I agree to ensure this plan is implemented in the work area | | | | |  | | I agree to monitor this plan | | | | | |
| Signature: | | | | | Date: | | Signature: | | | | | Date: |