A Back to Work (BTW) provider completes and submits this form to ACC on the date the client is discharged from the BTW programme.

Submit this form to the ACC contact person or claims@acc.co.nz

|  |  |
| --- | --- |
| 1. Client details | |
| **Client name:** | **Claim number:** |
| **Date of injury:** | |

|  |  |
| --- | --- |
| 3. Supplier Contact details | |
| **Supplier company name:** | **Service Delivery Company name:** |
| **Lead Provider name:** | **Lead Provider phone:** |
| **Lead Provider email address:** | |

|  |  |
| --- | --- |
| 3. Completion Outcome | |
| Outcome | Outcome Achieved  *Tick which applies* |
| Rehabilitation complete for the pre-injury role and this role is now considered sustainable  Pre-Injury role: |  |
| The client is considered work ready for vocational independence |  |
| Obtained employment  Hours per week:      Job Type/Role:  Other details: |  |
| No outcome achieved |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 4. Rehabilitation | | | |
| Confirm the rehabilitation completed to achieve and confirm the outcome above  *Include the vocational training and rehabilitation provided to the client and the date it was completed. Also include any previously recommended vocational training and rehab not provided and the reason why* | | | |
|  | | | | |
| List the work types from the IOA/IMA that the client is now considered work ready for |  | | | |
| List any additional work types (not from the IOA/IMA) that you have identified and consider the client is work ready for |  | | |
| List any work types assessed as medically sustainable (or likely to be) in the IMA that the Client is **not** considered work ready for |  | | |
| If no outcome was achieved, please give details as to why *(including any partially achieved outcomes)*: | | | |
| Does this client require any more assistance from ACC? | | Yes | No |
| If yes, what assistance is required? | | | |
| Any additional comments: | | | |

|  |  |
| --- | --- |
| 5. Provider declaration and signature | |
| I declare the information provided by me on this form is, to the best of my knowledge, accurate and complete. | |
| Provider name: | Provider discipline: | |
| Signature: | Date: |

When we collect, use and store information, we comply with the Privacy Act 2020 and the Health Information Privacy Code 2020. For further details see ACC’s privacy policy, available at [www.acc.co.nz](https://aus01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.acc.co.nz%2F&data=04%7C01%7CSonia.DeLautour%40acc.co.nz%7Cf3a57126063245d3c61608d8708c27c8%7C8506768fa7d1475b901cfc1c222f496a%7C0%7C0%7C637383094545478020%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=2AC5zj72t8zqZ6QVZvnU5gV1azY96dySBL%2FjWbj2uac%3D&reserved=0). We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.