Job search providers use this form to set out a plan for the delivery of the Job Search Service and to summarise the service once it has been completed. Please tick below to indicate which type of report this is and complete the appropriate sections.

**Initial report:** Please complete sections 1 to 5 and sign section 6

**Completion report:** Complete sections 1, 2, 4, 5 and sign section 6

When you’ve finished, please send a copy to the ACC contact person.

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

|  |  |
| --- | --- |
| 2. Contact details | |
| Lead supplier company name: | Lead supplier contact person: |
| Treatment provider company name: | |
| Treatment provider name: | Treatment provider email address: |
| ACC contact name: | ACC contact person email address: |

|  |
| --- |
| 3. Initial assessment |
| Summarise your assessment completed with the client: |
| Overall job search goal (based on employment availability and opportunities): |

|  |  |  |
| --- | --- | --- |
| 4. Job search activities | | |
| Service components | Specific activities relating to service components | Service completion date |
| Job search plan |  |  |
| CV development/modification |  |  |
| Teaching job search strategies and skills |  |  |
| Interview preparation/interview techniques |  |  |
| Providing job seeking advice |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| 5. Completion report | | |
| Was the overall job search achieved? | Yes | No |
| If yes, what date was it achieved? | | |
| Was a return to work achieved? | Yes | No |
| Provide a summary of the outcomes achieved as part of the service | | |
|  | | |
| If the client has not achieved the overall job search goal, list the reasons why | | |
|  | | |
| Are there any recommended follow-up actions required by ACC? | Yes | No |
| If yes, give details: | | |
| Is there related information attached eg work trial tasks and hours worked? | Yes | No |
| If yes, please give details: | | |
| Other comments: | | |

|  |  |
| --- | --- |
| 6. 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: | |
| 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.