If you’re a Pathways to Employment (PTE) provider, please complete and submit this form on the date you discharge the client from their PTE programme.

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

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

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

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| 3. Completion report |
| Result | Expected result achieved | Hrs per week | Completion date - please note if achieved or expected |
| Same job, same employer | **[ ]**  Yes | **[ ]**  No |       |       | **[ ]**  Achieved | **[ ]**  Expected |
| Modified job, same employer | **[ ]**  Yes | **[ ]**  No |       |       | **[ ]**  Achieved | **[ ]**  Expected |
| New job, same employer | **[ ]**  Yes | **[ ]**  No |       |       | **[ ]**  Achieved | **[ ]**  Expected |
| Similar job, new employer  | **[ ]**  Yes | **[ ]**  No |       |       | **[ ]**  Achieved  | **[ ]**  Expected  |
| Modified job, new employer  | **[ ]**  Yes  | **[ ]**  No |       |       | **[ ]**  Achieved  | **[ ]**  Expected  |
| New job, new employer  | **[ ]**  Yes | **[ ]**  No |       |       | **[ ]**  Achieved  | **[ ]**  Expected  |
| Other  | **[ ]**  Yes | **[ ]**  No |       |       | **[ ]**  Achieved  | **[ ]**  Expected  |
| Provide details of other: |       |
| Please list all activities completed to support this completion report | Confirm a copy has been attached to the report |
|       |       |
|       |       |
|       |       |
| Based on the job options identified in the IOA/IMA did these activities address all barriers to achieve the outcome?  | **[ ]**  Yes | **[ ]**  No |
| If no, please give details as to why:       |
| Does this client need any more assistance from ACC? | **[ ]**  Yes | **[ ]**  No |
| If yes, what help is required?       |
| Other comments/relevant information attached? | **[ ]**  Yes | **[ ]**  No |
| If no, please give reason:       |  |  |

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| 4. 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.