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.

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

|  |  |
| --- | --- |
| 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: |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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: | | | |  | | | |  | |

|  |  |
| --- | --- |
| 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.