

Workplace rehabilitation survey

School/Workplace: _____ Date: ____ / ____ / _____

Rehabilitation and Return to Work Coordinator (please circle): Region Central office School

Injury type (please circle): Physical Psychological Other

Nature of injury or illness: Work related Non-work related

In response to the following statements, please circle the number that describes your opinion. Please add further comments at the end of the survey.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Before I participated in rehabilitation, I was aware that workplace rehabilitation was available for both work and non-work related injuries or illnesses.	1	2	3	4	5
The length of time between when my injury/illness was reported and when my Rehabilitation and Return to Work Coordinator first contacted me was reasonable. If possible, please specify the length of time it was before the Rehabilitation & Return to Work Coordinator initiated contact with you: _____	1	2	3	4	5
I am satisfied with the level of confidentiality provided by the Rehabilitation & Return to Work Coordinator	1	2	3	4	5
When I could not perform my usual duties, my Rehabilitation and Return to Work Coordinator was helpful and supportive in providing/discussing options for alternative duties, locations or hours of work.	1	2	3	4	5
Workplace rehabilitation was beneficial and suitable to my needs.	1	2	3	4	5

Comments: _____

Thank you for taking the time to complete this survey.

Please email your completed survey to InjuryManagement@qed.qld.gov.au

Uncontrolled copy. Refer to the Department of Education Policy and Procedure Register at <https://ppr.qed.qld.gov.au/pp/workplace-rehabilitation-procedure> to ensure you have the most current version of this document.