Queensland Government
Department of Education, Training and the Arts

Workplace Rehabilitation Survey
CM19

District/Workplace: _____ Date: ____ / ____ / _____

Rehabilitation & RTW Coordinator (please circle): District Region Central Office School

Injury Type (please circle): Physical Psychological Other

Nature of Injury (please circle): 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
1. I was aware that workplace rehabilitation programs existed for both work and non-work related injuries or illnesses before I participated in a program.	1	2	3	4	5
2. The length of time between when my injury/illness was reported and my Rehabilitation and Return to Work Coordinator first contacted me was reasonable.	1	2	3	4	5
If possible, please specify the length of time it was before the Rehabilitation & Return to Work Coordinator initiated contact with you: _____					
3. I am satisfied with the level of confidentiality provided by the Rehabilitation & Return to Work Coordinator.	1	2	3	4	5
4. 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
5. My rehabilitation program was beneficial and suitable to my needs.	1	2	3	4	5

Comments:

_____

_____

_____

_____

Thank you for taking the time to complete this survey.
Please fax your completed survey to (07) 3237 1664 or post,
in an envelope marked "Private and Confidential", to:

Organisational Health Unit
PO Box 15033
Brisbane City East QLD 4002