

Note: The *Allied health providers guidelines for forms* are available from Q-COMP at [www.qcomp.com.au](http://www.qcomp.com.au) or call 1300 789 881.

Date of assessment: \_\_\_\_\_

**Worker's details**

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Claim number: \_\_\_\_\_  
 Contact number: \_\_\_\_\_

**Job seeker plan details**

Date Job Seeker Plan commenced: \_\_\_\_\_  
 Plan completion date: \_\_\_\_\_

**Provider's details**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_

**Suitable employment option goals**

The following jobs are agreed to by both the worker and provider as realistic options:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Job seeker plan**

Agreed actions	By whom	Date completed

**Worker's agreement** (delete any words which do not apply)

- I have read and understand the complete plan. \_\_\_\_\_
- I agree/disagree with the above plan. \_\_\_\_\_
- I will/will not carry out the actions as stated above. \_\_\_\_\_

Worker's signature \_\_\_\_\_ Date \_\_\_\_\_

Provider's signature \_\_\_\_\_ Date \_\_\_\_\_