

Rehabilitation at the workplace

Employer's feedback



Work trial

Job coaching

Rehabilitant	Name	Personal identity code
Employer	Employer's name	
Implementa- tion	Start date	End date
	Tasks	
	Absences (if any) and reasons for them	
	Were working hours changed during the work trial/job coaching or were there other arrangements? No Yes; please specify	
Impact of health status	Did the rehabilitant's health affect the work? No Yes; how and in which tasks?	
Work trial	In your view, the rehabilitant is able to work full time part time Not at all	
	Plan for the future the rehabilitant will continue working for us only the agreed work trial was implemented the rehabilitant needs training in the field to find employment other plan, please specify	
Job coaching	Will the rehabilitant continue working for you? Yes No, why?	
More information		
Date and place		
Signature		

Please submit this feedback immediately after the rehabilitation at the workplace ends