

Fit for Work (FFW) Service

Intervention outcome report

Claim and referral details			
Worker name			
Date of Birth		Date of Injury	
Claim Number		Claims Agent	
Date of Referral		Closure Date	
Fitness Upgrade Program			
Start date (DD/MM/YYYY)		End date (DD/MM/YYYY)	
Fitness pathway service (list)	Contribution to worker's certified medical capacity		

Outcome

Certified Capacity

Pre Injury Hours	hours per week
Current hour per week	hours per week

Outcome Requested

- FW242 - No increase in capacity
- FW246 - Certified for less than pre-injury hours
- FW248 - Certified for full pre-injury hours

Evidence of Outcome Achieved (to be attached)

- Work Capacity Certificate (mandatory) Medical evidence Other
- Please provide details*

Considerations and Recommendations

Considerations which may impact ability to maintain capacity *Please provide details*

Recommendations to consider to gain and/or maintain suitable employment *Please provide details*

Provider details

Consultant Name:			
Provider		Provider number	
Phone number		Email	
Date completed			

Date of lodgement