ReturntoWorkSA

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Emergency Department

Nurse Practitioner Work Capacity Certificate

A. Patient and employer details

Family name: Given names:

Claim number (if known): Employer name:

Date of birth:

B. Injury details and assessment

I examined you on: for injury(s)/condition(s) you stated occurred/developed on:

The stated cause was:

The injury(s)/condition(s) you presented with is/are consistent with your stated cause(s) ☐ Yes ☐ No

My clinical diagnosis/es based on my examination of you and other available information is:

Other comments/clinical findings:

C. Certification (for a maximum period of 7 days)

In my opinion, you: (please tick whichever apply)

☐ have recovered from your injury/condition and are fit to return to your normal duties and hours on:

☐ some further treatment may be required

☐ are fit to perform suitable duties that accommodate your functional abilities from: to

☐ are medically unfit to undertake suitable duties while recovering from your injury for ☐ days (up to and including a maximum of 7 days).

Note: Certification based on functional capacity, not available duties.

Reason:

Comments:

D. Nurse Practitioner's details

Nurse Practitioner's name:

Address: Signed:

Provider Number: Completion date:

Please attend a General Practitioner for ongoing treatment and certification.