

Work Capacity Certificate

Version 2 effective 1 July 2017



A. Patient and employer details

Mandatory

Family name:

Given names:

Claim number (if known):

Employer name:

Date of birth:

B. Injury details and assessment

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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

Is this a new injury/condition?

Yes

No

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

Other comments/clinical findings:

C. Certification

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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:

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

are medically unfit to undertake suitable duties while recovering from your injury for the period:

Reason:

Note: Certification based on your functional ability, not available duties.

I estimate you should have functional capacity to return to work in days weeks **OR** uncertain at this stage
(estimated timeframe will assist with planning for return to safe work)

I would like to review your progress on:

or

at your next medical consultation

Comments:

D. Treatment plan

Complete all fields relevant to your patient



The following treatment plan is aimed at assisting your recovery and return to work:

I have referred you for the following clinical treatment:

Medical specialist (Name & specialty)

Psychologist (Name)

Physiotherapist (Name)

Other (Name & discipline)

E. Functional ability

Complete all fields relevant to your patient



Your ability to work is affected by **this** injury(s)/condition(s) as follows:

(please select applicable functions – blank fields indicate that limitations don't apply. Please include any impact of medications on function)

No restrictions - go to section G (Doctor's details)

Physical function

Can With modifications Cannot

Comments (e.g. details of capacity or limitations that will assist in identification of suitable duties)

Sitting:

Standing/walking:

Kneeling/squatting:

Carrying/holding/lifting:

Reaching above shoulder:

Bending:

Use of affected body part:

Neck movement:

Climbing steps/stairs/ladders:

Driving:

Mental health function

Not affected Partially affected Affected

Attention/concentration:

Memory (short term and/or long term):

Judgement (ability to make decisions):

Other functional considerations - not listed above

I have prescribed medication(s) that could impact upon your ability to undertake some activities.

Details:

I recommend:

A graduated increase in working hours over weeks from hours a day to your normal hours/ hours a day
Non-consecutive working days for a period of days or weeks

F. Communication

Optional



Preferred contact method: phone email fax writing visit

G. Doctor's details

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Doctor's name:

Provider Number:

Address:

Email address:

Fax:

Signed:

Phone:

Completion date: